CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

COUNTERPART

C&D/WHITEHALL LABORATORIES PHARMACIST BRIEFING

18 November 1995

Assistant exam put back to January

DoH: no compensation for small contractors

12pc of returned drugs are unwanted repeats

New developments with antibiotics and NSAIDs

The way ahead for POM to P switching

Astra capitalises on Fisons' R&D strengths

Hadley to front Lib Dem challenge in West Worcs

It shows he nose his business.

- NEW, flu-strength formula from Beechams.
- Decongestant, Vitamin C and maximum dose Paracetamol.
- £3.4m Beechams TV spend November '95 - February '96.

PRODUCT INFORMATION: PRESENTATION: Powders containing Paracetamol Ph Eur 1000 mg, Ascorbic Acid Ph Eur 40 mg and Phenylephrine Hydrochloride Ph Eur 10 mg. **USES**: Short term symptomatic relief of influenza, feverishness, chills and colds including headache, sore throat pain, aches and pains, nasal congestion, sinusitis and its associated pain, and acute nasal catarrh. **DOSAGE AND ADMINISTRATION**: Dissolve contents of sachet in hot water before taking. **Adults and children aged 12 years and over:** One sachet every four to six hours, up to four sachets in any 24 hours. Obtain medical advice if symptoms persist for more than seven days. **Children under 12 years**: Not recommended except on medical advice. **CONTRAINDICATIONS**: Hypersensitivity to any of the ingredients. Hepatic or severe renal impairment, hypertension, hyperthyroidism, diabetes, heart disease. Treatment with MAOIs, tricyclic antidepressants or beta-blockers. **INTERACTIONS**: Paracetamol: coumarin anticoagulants (prolonged use of paracetamol only), drugs that affect the liver including enzyme-inducing drugs and alcohol (increased hepatotoxicity), metoclopramide and domperidone (increased paracetamol absorption), and cholestyramine (decreased paracetamol absorption). Phenylephrine: beta-blockers, anti-hypertensives, MAOIs. **USE IN PREGNANCY AND LACTATION**: Use on the advice of a doctor. **ADVERSE REACTIONS**: Paracetamol: skin rashes and other allergic reactions occur occasionally, blood dyscrasias have been reported rarely. Phenylephrine: normal doses infrequently elevate blood pressure with headache, dizziness, vomiting, diarrhoea, insomnia and rarely palpitations. **LEGAL CATEGORY**: GSL. **RETAIL PRICE**: 5 sachets £2.29. **PRODUCT LICENCE NUMBER**: PL0079/0323. Further information is available from the product licence holder: SmithKline Beecham Consumer Healthcare, Brentford TW8 9BD U.K. **DATE OF PREPARATION**: October 1995. Beechams is a trade mark.

SmithKline Beecham
Consumer Healthcare

COMMENT

The value of the OTC business going through pharmacies from products that have moved from POM to P since the beginning of 1993 is $31 million (see p738). With NHS margins having fallen to an estimated 16.5 per cent, any pharmacy proprietor who is not paying careful attention to his medicine sales does not deserve to be in business. In a pharmacy with a 70:30 NHS to retail sales split, and respective gross margins of 19 per cent and 34.8 per cent (CSO 1993 figures, excluding Boots), gross profit works out at $13.30 and $10.40 per $100 of sales. "It will not require much more pressure on NHS returns for retailing to have equal importance," a recent Verdict report on 'Chemists & Drugstores' comments, and pressure there certainly has been! Since 1988, the number of scripts dispensed has risen by 21 per cent, while fee income in real terms has fallen by about a quarter, a point PSNC will no doubt be making yet again as this year's pay talks get under way.

It pays to play to your strengths. Pharmacy medicines are the pharmacist's usp. Much has been done in the past two years to emphasise that point. The insistence on sales protocols and efforts to raise standards of service by demanding assistants have a sound knowledge base indicates the Royal Pharmaceutical Society is well aware of this. The PAGB and the Society have worked hand in hand to promote self-medication in recent years. The Proprietary Association is looking to develop the sector by encouraging GPs to become more familiar with OTC treatments. The Society is promoting, in effect, a new group of OTC products, which could be made available from a pharmacy after initial diagnosis by a doctor (see pp742-743). Innovative thinking such as this is required if the pharmacy is to remain pre-eminent as the community healthcare outlet.

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REGULARS

Pharmacist assistant training reminder

- Experienced assistants have two opportunities to pass a multiple choice paper, which may be on any of the following three dates next year: January 25, May and November. An experienced assistant is defined as one who completed a course of training before January, 1992, or who had not completed such a course but had worked in a pharmacy for not less than 16 hours/week for three of the past five years and whose work had a significant component of sales of medicines.
- 'Newly-trained' staff must be undertaking a designated assistants training course by July 1, 1996. This must be completed by December 31, 1996. Newly-trained staff are defined as those who, since July 23, 1994, have started a course accepted by the Distributive Occupational Standards Council as providing the necessary evidence of underpinning knowledge required for the pharmacy unit of the retail level 2 NVQ, who are not required to take the accompanying multiple choice exam paper.
- New staff must be undertaking an accredited course by July 1, 1996.

MCQ delay offers second chance

The first multiple choice question examination for experienced assistants takes place on January 25, 1996, not the end of this month as expected.

As a result, the Society is giving assistants a second chance to apply to sit the exam. Applications should be made in writing to: Room 309, Royal Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1 7JN, stating the name(s) of assistants, the pharmacist supervising the exam and the name and address of the pharmacy where assistants are working. This information must reach the Society by November 30.

An acknowledgement and information pack, containing further instructions and sample questions, will be sent to assistants, via their supervising pharmacists, at the end of this month. Exam papers will be distributed to supervising pharmacists on January 22, 1996.

The 30-minute exam,comprising 55 ordinary multiple choice questions and five case study questions with true/false answers, can be sat at any time on January 25. Supervising pharmacists are to return papers for marking by January 26, along with a two-part declaration confirming that the assistant(s) qualifies to sit the exam and that it was sat under exam conditions. A fee of $10 per assistant must also be sent.

Results and certificates for successful candidates will be sent out by March 7, 1996.

Applications received after the November 30, 1995, deadline will automatically go forward for the second MCQ examination, which is to be held in May, 1996. A third MCQ is scheduled for November, 1996.

Sample multiple choice examination questions

Which of the following ingredients is suitable for the treatment of hayfever?
(i) dextromethorphan (ii) loperamide (iii) miconazole (iv) astemizole.

When treating diarrhoea which of the following statements is true?
(i) loperamide (eg Imodium) can be given to children under 12 years (ii) fluid replacement (eg Dioralyte) may be sold for young babies without consulting the pharmacist (iii) pregnant women should be referred to the pharmacist (iv) diarrhoea can be treated with senna.

A cream containing ketoprofen would be suitable for:
(i) itching (ii) sprains and strains (iii) nappy rash (iv) acne.

Footcare preparations containing salicylic acid should not be used by people with:
(i) high blood pressure (ii) hayfever (iii) conjunctivitis (iv) diabetes.

The case studies are as follows (statements marked True/False).

A young man in his mid-20s asks for some tablets for his hayfever, which is particularly troublesome at the moment. He is just about to embark on a long car journey during which he will be driving. He is not taking any other medication.
(i) a product containing chlorpheniramine would be suitable (ii) all products for hayfever should be taken twice daily, or more often (iii) preparations containing terfenadine (eg Triludan) do not generally cause drowsiness (iv) eye drops containing sodium cromoglycate (eg Opticrom) can be used when taking tablets containing astemizole (eg Pollon-Eze).

The answers are: iv, iii, ii, iv and F, F, T, T.

CPG seeks input from pharmacists

Pharmacists are being asked for ideas for the Community Pharmacy Group's mission statement, which will be fed into the Royal Pharmaceutical Society's 'Pharmacy in a New Age' initiative.

Four key issues have been identified so far: marketing and commitment from the profession; resources utilisation and how best to use the pharmacist's skills; information technology; and practice research and how it can be used by the profession.

Information should be submitted to Janet Flint at the RPSGB before December 15.

Tackling stoma supply

The Ulster Chemists' Association is to examine ways of reducing direct supply of goods to stoma care patients after its Committee meeting last week.

The Committee also expressed its concern over the omission of pharmacy input into the Regional Strategy for Health and Social Wellbeing 1997-2002 and plans to write to redress this.

NHS backs discharge planning study

The NHS Research and Development Executive has awarded $70,000 to the Centre for Pharmacy Practice at the London School of Pharmacy to continue research into improving hospital discharge planning.

Project leader Catherine Duggan has approached 170 community pharmacies within the City & East London Family Health Services Authority. The project aims to reduce the discrepancies between supplies of prescribed drugs that patients obtain post-discharge.

Additional information on the hospital discharge drugs will be provided to the community pharmacists, with any interventions monitored.

A total of 1,000 general medical patients discharged from the Royal London Hospital will be followed up in their homes over a 12-month period, with drug supply discrepancies noted. Patients are divided into two groups: those using the current system and those returning with additional information.

"I would hope that the project would achieve a reduction in discrepancies," says Ms Duggan. The results are expected at the start of 1997.

Counterpart targets the respiratory tract

The Pharmacists Briefing on the sixth module of the Whitehall-sponsored Cambridge Counterpart assistant's training course appears on pp735/6 of this week's issue. The module covers respiratory tract infections.

Extra modules are available from Whitehall representatives, or Tracy Matthews or Charlotte Batchelor on 0181 747 8797.

We hope to announce soon that Cambridge Counterpart has been accredited to allow assistants to comply with the Royal Pharmaceutical Society's training requirements. In the meantime, those who want to register for interactive telephone marking of their course work should contact Claire Newman on 01732 364422.

NPA and OFT offer joint RPM submission

The National Pharmaceutical Association has agreed with the Office of Fair Trading to a joint submission of factual data if resale price maintenance should be referred to the Restrictive Practices Court.

While the OFT inquiry continues, the NPA is looking for examples of pharmacy businesses which will be particularly affected should RPM end. Suppliers of pharmacy EPoS equipment and businesses with well-documented sales data have been contacted to help.

While it is the economic argument that has to be won with the OFT, the public is more likely to be swayed by emphasising the service a pharmacy provides, and that medicines are not ordinary items of commerce, says NPA head of public affairs Colette McCreedy.

She has so far briefed 18 national newspapers and arranged a total of 17 radio interviews on the subject of RPM. The NPA has also bought a page in *Parliamentary Briefing*, a lobbying magazine.

Government 'No' to compensation

The Department of Health has refused to consider compensation for small pharmacies which decide to close.

The Pharmaceutical Services Negotiating Committee had been told that the Department was prepared to discuss a compensation scheme for the financial year starting in 1997. The scheme would have been available to pharmacies currently dispensing fewer than 1,100 items a month.

The Department has now turned down the proposal. The reasons given are that the Government has moved towards 'better targeting' of the money available by removing the indiscriminate premium payment available to all small pharmacies and expanding the scope of the essential small pharmacy scheme. The Government did not want to change its stance by agreeing to a compensation scheme which encouraged the closure of the smallest pharmacies at a time when the indiscriminate subsidy to those pharmacies had been removed.

PSNC last week described the reasons behind the decision as "odd" and promised that it will take the matter up with the Department again.

CPPE on the roll

The Centre for Pharmacy Postgraduate Education reported a 37 per increase in distance learning packs supplied in 1994/95.

A total of 55,468 packs were supplied. However, less than 20 per cent were returned. In addition, 3,105 computer-assisted learning packages were distributed and 589 workshops were run.

The CPPE may integrate distance learning and workshop materials as foundation subjects for certificate and diplomas in clinical and community pharmacy at the Schools of Pharmacy.

CPG to hit the road in 1996

The Community Pharmacy Group is to begin a series of roadshow meetings next year.

Following on from the organisation's inaugural open meeting at the Royal Pharmaceutical Society's headquarters, it is planning an "intensive" programme for 1996.

At last Sunday's meeting, it was revealed in a series of votes that community pharmacists want control of repeat dispensing, but are less confident about monitoring and reviewing outcomes and compliance.

However, Peter Curphey, chairman of the CPG's practice committee, pointed out that if pharmacists want control of repeat dispensing, then they will also have to monitor and review outcomes and compliance.

Taking this idea further, it became clear that the majority of the 80 attendees felt that pharmacists should have a greater role in prescribing.

While there was considerable emphasis on pharmacist specialisation, such as offering diabetic and asthmatic clinics, there appeared to be a definite lack of confidence among pharmacists that they had the necessary skills to offer this.

Dr Jonathan Shapiro, senior fellow at the Health Services Management Centre at the University of Birmingham, outlined various pharmacy models.

He offered the option of pharmacists becoming alternative providers of primary care, where existing services are weak, such as in an inner city area with no GP surgery.

He pointed out that changes within the NHS were leading to the evolution of the primary care unit, as exemplified by the GP fundholding practice. But Dr Shapiro did not see any reason why pharmacists could not be PCU managers either from an administrative or from a clinical viewpoint.

High-dose methadone concerns Scots

The Royal Pharmaceutical Society's Scottish Executive is to draw the Scottish Office's attention to the question of pharmacists supervising the self-administration of methadone in doses which exceed the normal therapeutic range.

The Scottish Office has established a working group to prepare a statement of good practice in substitute prescribing for drug misusers in Scotland. The aim is to provide helpful advice for general practitioners and others involved. The group is expected to report by March 31, 1996.

The Scottish Executive has updated its interim position paper on pharmacist supervision of methadone self-administration and has sent copies to relevant organisations.

At last month's meeting, members felt that, in developing these services, attention had not been given to the position of pharmacists required to supervise doses above the norm. The question of dosage needed effective communication between pharmacists and doctors.

Patient packs delay

Regulations to allow patient pack dispensing to take place will not be laid before December 1.

As such, pharmacists can supply the exact quantity stated on a script, not the nearest patient pack size. PSNC advises pharmacists that where they have used a proprietory patient pack that this is clearly endorsed. It understands that the DoH has contacted manufacturers to ensure bulk stock will remain available.

£100,000 of unwanted medicines a year

Over £100,000 of unwanted medicines are returned to pharmacies in South Tyneside every year. This accounts for almost 1 per cent of the area's family health services authority total drugs budget.

A three-month survey of 22 pharmacies in the area, conducted at the end of last year, revealed that 12 per cent of medicines returned were unwanted repeat prescriptions.

"There's a lot community pharmacists could do to help GPs look at their repeat prescribing," says the FHSA's pharmaceutical adviser, Wendy Broderick.

Other areas the study highlighted for possible pharmacist impact are:

- anti-infectives – the majority were returned because patients chose to stop therapy; pharmacists could counsel patients to complete the course
- laxatives and analgesics are frequently written on repeat prescriptions, but used on a 'prn' basis.

The FHSA is aiming to talk to local medical committees to encourage GPs to write monthly prescriptions for newly-initiated drugs. "One of the most common reasons people brought back drugs was because their GP changed their tablets," says Ms Broderick. Some 26.7 per cent of musculo-skeletal items and 31.1 per cent of diuretics were returned for this reason.

Get connected

A direct dial service is being set up for pharmacists wanting to reach the NPA's information department. Dialling 01727 858687 ext 322 on the voice connect system gives members direct access, with the option of leaving a message if all lines are busy.

Allan Sharpe as MP?

Newbridge pharmacist Allan Sharpe has said he wants to serve a future Labour government, reports the *Cardiff Western Mail*.

Seton will sort it out

No one will lose out following last week's news that carbaryl containing headlice products are to become POM, says Seton. Reps will be calling on customers to sort out any problems.

Leeds goes private

Leeds City Council has told people on low incomes to ask for a private script when the cost is less than the prescription charge.

Into the record book

October, 1995, was the busiest month ever for the NPA's information department, with staff dealing with an average of 390 calls a day. The Pill scare, the rescheduling of temazepam, free scripts for men over 60 and the RPM issue all contributed.

PAS reminder

Invites for the Pharmacists Action on Smoking meeting to be held this month in Harpenden, Hertfordshire, are wrongly dated. Would-be attendees are reminded that the date is November 29. The next National No Smoking Day is March 13, 1996, with the logo 'Put a NOT in it'.

Doctor petition

Coaches carrying residents from villages in Gloucestershire and Lincolnshire will deliver petitions to Downing Street on November 22 in support of GP dispensing.

Complaints ombudsman

The Health Service Ombudsman is to be given new powers to investigate complaints against pharmacists. The Health Service Commissioner (Amendment) Bill extends the HSO's role.

Rapped up

The picture credit for the bandages feature in Pharmacy Update (*C&D* Nov 4) should have read Tubifast from Seton Healthcare.

PSNC to push recruitment and motivation problems in pay fight

The Pharmaceutical Services Negotiating Committee, in its 1996-97 pay claim, will stress that the "recruitment, retention and motivation" of pharmacy contractors is suffering badly.

PSNC will also insist that contractors will take on new roles only if they are allocated specific, substantial payments on top of any normal increase in the global sum.

Details of the claim are yet to be finalised, but will be based on the inflation forecast, which will become clearer in the budget on November 28, and the anticipated script volume increase.

PSNC chairman David Sharpe said last week there was evidence of recruitment difficulties.

"Many pharmacies are having to be run almost full-time by locums because it appears there are not enough community pharmacists available to fill the vacancies," he said. "As far as retention is concerned, it's very clear that owner managers are leaving community pharmacy by selling to the multiples."

Advance payments – which PSNC now calls 'late payments' – had reached a state where many contractors could not pay their monthly accounts on time and some were losing discounts because of cash flow problems.

"We intend vigorously pursuing late payment as part of working capital and will bring it to the attention of MPs who will be attending our four lunches in November/December," said Mr Sharpe.

Fighting for RPM PSNC has agreed to become part of the group which is co-ordinating the legal issues involved in fighting for the retention of resale price maintenance on medicines.

Cross-border payments PSNC believes a health authority can pay for services, such as nursing and residential homes, supplied by a contractor whose place of business is outside that authority. The Department disagrees, so solicitors from the two organisations are having discussions.

Rationing of services The DoH has told PSNC it has "raised an important point and highlighted an omission in the regulations" by drawing attention to the way some authorities are rationing payments to pharmacies which supply services to homes.

Some authorities say they have run out of money halfway through the financial year, but PSNC maintains that agreements with pharmacies should stop only at the end of the year.

CD storage and temazepam PSNC is concerned pharmacies may have to buy new CD cabinets with the new temazepam regulations. The Committee is to explore the possibility of the DoH funding these installations, if pharmacists provide invoices. The Department has also suggested that temazepam scripts will attract no extra fee, because handwriting requirements will not apply. PSNC is to discuss this "totally unacceptable" arrangement with the DoH.

Managing treatment PSNC has set up a working group on the management of patient therapy, hoped to report next February.

Ups and downs on restoration front

It was a week of ups and downs for pharmacists seeking restoration to the Royal Pharmaceutical Society's Register last week.

The Statutory Committee deliberated for less than five minutes before deciding to reinstate Geoffrey Chaldecott, 62, of Bournemouth, Dorset. He was struck off in June, 1994, after selling diazepam without a prescription to a well known comedian for more than three years.

Mohammed Kanani, Moseley, Birmingham, also won back his right to practice. He had his name removed from the Register in August, 1992, for his part in a company which imported and distributed unlicensed drugs. At the time, he was a minority shareholder in the firm.

Oliver Dalley of New Addington, Croydon, lost his application to be reinstated. He had been taken off the Register after a conviction for dishonestly obtaining a British passport in 1993.

David Goody from Halifax also lost his application for restoration, following a striking off after being convicted of supplying controlled drugs to addicts in September, 1991.

Society highlights community care

The services pharmacists can contribute to community care are the focus of a Royal Pharmaceutical Society briefing session.

This week's meeting will outline the community pharmacy services available to 25-30 representatives of the voluntary sector, social services and others connected to community care.

The meeting will be chaired by Peter Curphey of the Community Pharmacy Group and addressed by the Society's Roger Odd and pharmacist Alison Ewing.

£113,000 for London pharmacies

Kensington, Chelsea and Westminster Family Health Services Authority has set aside £113,000 for pharmacy improvements.

The money has been awarded to 28 pharmacies within the area to install any of the following: access for the disabled; consultation areas; waiting areas; and health promotion areas. The maximum grant is £15,000 per pharmacy.

"We are developing facilities which will develop the extended role of the pharmacist. We are not just looking at purely dispensing and ratios of contracts to population," says the FHSA's contracts manager, Helen Lipieta.

The money is derived from the District Health Authority's health promotion budget in order to further health promotion via the pharmacy. As such, certain provisos will be attached to successful applicants: they must undergo FHSA health promotion training and they must display non-commercial leaflets tackling 'Health of the Nation' topics.

MCA in herbal talks

The British Health Food Manufacturers' Association is to meet with the Medicines Control Agency next week to try to reach agreement on the licensing of food supplements.

The BHFMA is concerned that products administered with a view to changing physiological function will be regarded as medicines, even if no medicinal claims are made. The proposals are put forward in the unpublished MAL 8 document 'Guidelines on borderline substances'.

Topical Reflections

Pharmacists advise PPP private patients

Customers of the private healthcare group PPP are now able to receive telephone advice on prescription and over the counter medicines from pharmacists as part of an information service launched this month.

Details of possible side-effects and interactions are given, but the PPP staff do not make recommendations on drug usage, referring callers to their own GP or community pharmacist.

The 24-hour service is part of a wider PPP Healthline initiative, with 18 full-time staff, including two pharmacists, nurses, midwives and medical librarians.

Assistance can be given to locate services in the caller's area, such as rota chemists or other medical and support facilities. Information is also provided to help members understand a particular illness and treatment procedures. Fact sheets can be sent by post, fax or the Internet.

The medical librarians are able to provide comprehensive medical information. Staff can access medical databases and useful articles and publications to compile tailor-made fact sheets.

Initial inquiries are followed up to ensure the inquiry has been dealt with satisfactorily.

Decision on Boots hearing this month

A decision on whether Boots the Chemist and its superintendent flouted Royal Pharmaceutical Society guidelines in the provision of services to patients in rural areas is to be given on November 30 (*C&D* October 28, p614).

In a major test case, the company is alleged to have continued providing a collection and delivery service in Durrington, Wiltshire, and Winterton, South Humberside, despite the opening of pharmacies in both villages.

Schering Award '95

Pharmacists who have made an outstanding contribution to pharmacy practice are eligible for the 1995 Schering Award.

Submissions can be made by any pharmacist and must include a 1,000-word statement, identifying the grounds for the nomination. Submissions should be sent to the Administrator, the College of Pharmacy Practice, University of Warwick Science Park, Barclays Venture Centre, Sir William Lyons Road, Coventry CV4 7EZ by December 31, 1995.

Every cloud has a silver lining

First there was the Pill scare and then there was carbaryl. Both have caused concern among my customers; both have created extra work for pharmacists; and both have produced a lot of dead stock on my shelves without any clear indication as to when the problem will be resolved.

Both could also have been better handled by the Department of Health: the Pill advice still being hotly opposed by some authorities, and branding carbaryl as potentially carcinogenic and then restricting its use to Prescription Only is a nonsense. After that kind of warning, what doctor in his right mind would ever again prescribe the stuff?

All in all, a difficult three weeks, but every cloud has a silver lining and from this fiasco has come the opportunity to demonstrate the advantage of the community pharmacist as an integral but independent member of the primary healthcare team.

Every new Pill script has allowed me to counsel on the proper change-over precautions and provide the necessary advice on a possibly new and unfamiliar Pill. Every inquiry about headlice treatment has allowed me to reinforce the message of prevention, limitation and effective treatment to the point where I am becoming hoarse and Dotty has renamed me the Headlice Kid!

But all this advice has been excellently received, both by grateful customers and harassed surgeries alike. It has been a wonderful opportunity for promoting my pharmaceutical *raison d'être* and it is an opportunity I have grasped with enthusiasm.

Nice one, or two ... or three!

When Bazuka Gel was launched, I was sceptical of its success, but, having seen sales accelerate out of sight, I am not surprised that a million packs have now been sold (*C&D*, November 11). What has surprised me is that, yet again, Dendron has stolen a march on the opposition and identified a dormant market, which it has taken by storm.

First there was Ibuleve, which was launched as the first of the OTC topical non-steroidal anti-inflammatory gels, then there was Otex for ear wax removal and now Bazuka.

All are markets that had received scant attention from the large players, markets that have demonstrated dramatic potential, but, most important, markets that are almost exclusively the prerogative of pharmacy.

These are the markets I enjoy, where counselling is vital with almost every sale. There are competing products which I could recommend, but Dendron has generated increased sales for me, and, while I enjoy its support I will continue to promote its winners.

It is now six months since the introduction of Bazuka Gel. With my luck, I anticipate winning a weekend on a health farm, but I am looking forward rather more to Dendron's next product launch in its continuing campaign of ensuring our mutual success.

Forewarned is forearmed

Dr David Horrobin, Scotia Pharmaceutical's chief executive, last week affirmed that community pharmacy is essential for the introduction of new patented products (**Business News**, November 11).

This placatory statement was in response to the announcement that Scotia intends expanding the sales of the Efamol range through grocery outlets. However, it leaves unanswered the question of what will happen to these new products once pharmacy has established their viability.

If they will be following Efamol into the local grocery store, then their introduction through pharmacy could be an exercise fraught with difficulty.

I am resigned to companies using community pharmacy as a test bed for products intended for eventual wider distribution, but I interpret Dr Horrobin's statement as being told before the event. If this is true, it could overstretch the limits of our future commercial co-operation!

Rage on!

And the first of your 'rages' is close to my heart. If the majority of the pharmaceutical industry can produce perfectly reasonable blister packs for the easy dispensing of various quantities, why do Beechams, Novex and 3M insist on being the exceptions?

Ovranette colour change

Wyeth says that as a result of the recent Pill scare, there has been a heavy demand for Ovranette. To maintain supplies, the company has introduced a yellow, sugar-coated Ovranette tablet in a gold foil blister. The outer carton is the standard Ovranette pink, but carries the flash message 'New yellow sugar-coated tablet'. The new tablets are the same strength, with the same active ingredients as the original white, uncoated tablets.
Wyeth Laboratories. Tel: 01628 604377.

Tilade for children

Tilade (nedocromil sodium) is now licensed for use in both adults (including the elderly) and children aged over six years.
Fisons Pharmaceuticals. Tel: 01509 634000.

ZD list correction

PSNC says that the list of products that has been added to the zero discount list because they require refrigerated handling (*C&D* November 4, p667) included four products that do not require refrigeration: Glucagon injection, Monoparin, Multiparin and Hepsal Solution 50iu/5ml. However, until discount is restored by the wholesaler involved these items will remain on the ZD list. With all items recently added to the ZD list, pharmacists are asked to ensure that no discount has been received before endorsing 'ZD'. Not all wholesalers agree on which products are affected.

Atropine Sulphate Inj

Aurum Pharmaceuticals has launched Atropine Sulphate Injection 3mg/10ml in a prefilled syringe. The product is presented in single tamper-evident cartons. The basic NHS price for a single syringe is £4.32. The product is being distributed by:
Distriphar UK. Tel: 01895 837779.

Volital supplies

Volital (pemoline) will be available through wholesalers again from mid-November. The pack size has been increased to 50 tablets with a basic NHS price of £3.06. LAB says the interruption of normal supply was due to manufacturing difficulties.
Laboratories for Applied Biology. Tel: 0181 800 2252.

Data sheet changes for Caverject

There have been a number of changes to the data sheet for Caverject as follows:

- the diagnostic use of Caverject is fully described, with a 20mcg injection now recommended for subjects without evidence of neurological dysfunction
- after an initial dose of 2.5mcg, patients may be given 5 or 7.5mcg, depending on the response. Incremental increases of 5-10mcg can be given subsequently. If there is no response to the first dose, a second dose may be given within one hour
- contra-indications include patients with various categories of penile anatomical deformities, and patients in whom sexual activity is medically inadvisable or contra-indicated. Full details can be found in the amended data sheet
- additional warnings concerning those patients who develop penile anatomical deformities, or who have underlying, treatable causes of erectile dysfunction have been added. Full details are included in the amended data sheet
- in the side-effects section, information about the incidence of penile pain and haematoma with Caverject treatment has been revised, as have the incidence figures for priapism (0.5 per cent) and fibrosis (1-1.5 per cent). Full details in the new data sheet.

Upjohn Ltd. Tel: 01293 531133.

MEDICAL MATTERS

Bed sharing and cot death

Bed sharing has not been found to be a major risk factor in sudden infant death syndrome, according to a Californian study in the *British Medical Journal*. The findings contradict previous studies which have noted a link.

The study looked at whether bed sharing with a parent was more prevalent in infants who died of sudden infant death syndrome than in control infants. Day and night sleeping arrangements and differences in bed sharing practices among races were also investigated.

A sample of 200 white, African-American, Latin American and Asian infants who had died of the syndrome were compared with a random control sample of 200 living infants.

Of the infants who died from the syndrome, 45 (22.4 per cent) deaths occurred while sharing a bed. However, this weak association was not significant when potential confounders, such as intercom use, maternal education and neonatal medical conditions, were adjusted for. The study also found no interactive effect between bed sharing and maternal use of alcohol, tobacco or recreational drugs.

Bed sharing during the day was more common in African-American and Latin American families than white families. However, there was no evidence of differences between bed sharing during the day and night and sudden infant death syndrome.

The researchers conclude that larger studies are needed to investigate unknown physiological or behavioural risk factors of bed sharing and the syndrome.

- Overheating as a risk factor in cot death is being addressed in a new initiative. The Foundation for Sudden Infant Death and Mothercare have teamed up for the 'Feet to Foot' campaign to encourage parents to put baby to bed at the foot of the cot, to prevent the child wriggling under the bedding and becoming too hot. This is in addition to putting babies to sleep on their backs.

BBC's 'Watchdog' 'misinterprets' Roche over pharmacy guidelines for anti-malarial drug

Roche says it has not issued 'emergency guidelines' on Lariam to pharmacists and GPs, as stated on this week's BBC 'Watchdog'. This is the second week the drug has featured (*C&D* November 11 p686).

Roche managing director Nic Holladay says the guidelines referred to were, in fact, letters sent to pharmacists and GPs last week, correcting inaccuracies made on the previous 'Watchdog'. The letter also carried the the company's drug information number for further details.

"We are rather annoyed that 'Watchdog' has misinterpreted what we have done. We have responded to all their requests for information and we don't believe they have utilised that information in an objective and reasonable manner," he says.

Antidepressants prove unsatisfactory

Over a third of depressed patients are dissatisfied with their antidepressant treatment, citing problems such as tiredness, reduced libido and addiction fears.

Almost one in five people have experienced depression at one time or another, and less than half of them had been prescribed antidepressants, according to a MORI poll of over 6,000 people conducted for Bristol-Myers Squibb.

Of those who were taking antidepressants, 16 per cent said they were more tired than usual, 8 per cent said they had lost interest in sex and only a third said they felt less depressed.

Londoners were the most depressed in the survey, then people in the Midlands and Scotland.

Quellada tumour link dismissed

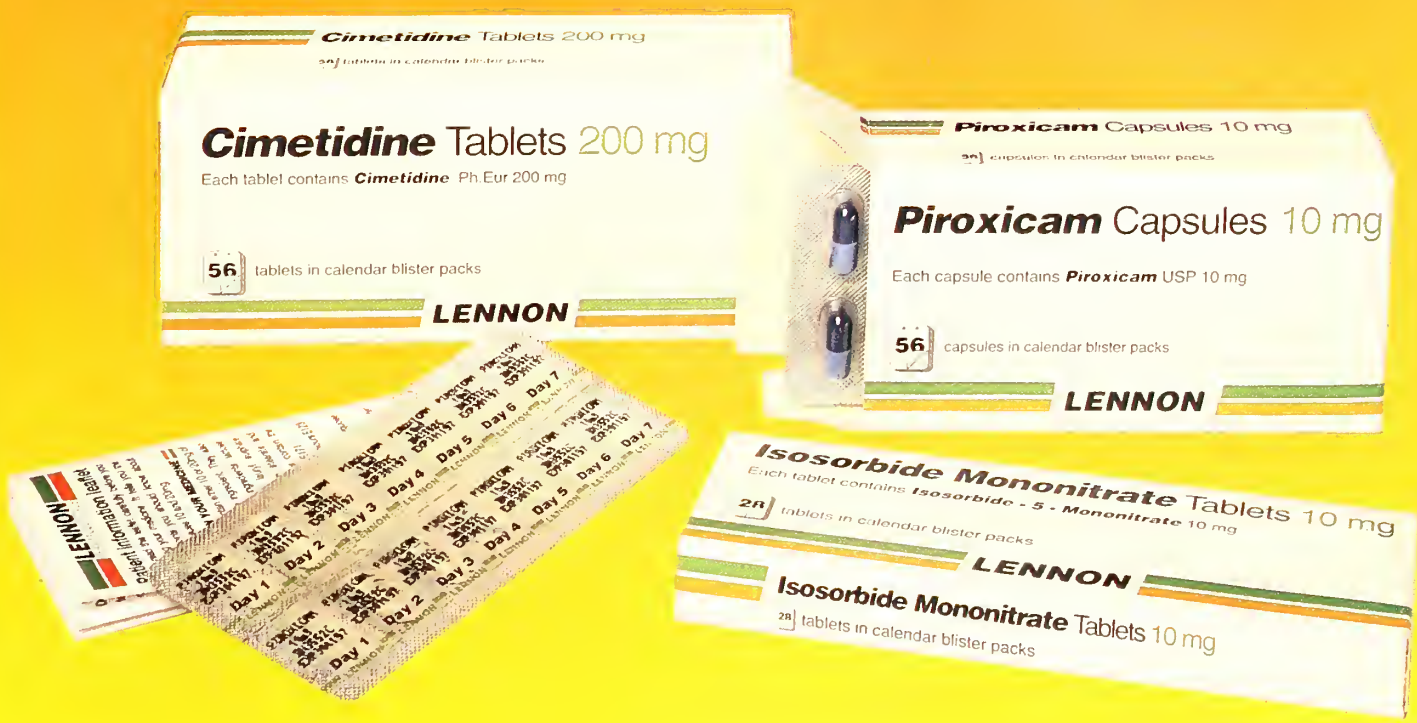
Stafford-Miller has dismissed claims linking Quellada and other anti-lice, lindane-based lotions with cancer.

The company says: "There are no authoritative studies in the worldwide medical literature linking the use of such products to cancer of any kind."

The response follows a report in *The Observer*, which claimed that the Government was refusing to ban OTC sales of lindane, despite advice from the World Health Organisation which linked the lotion to medical problems.

Stafford-Miller says Quellada (lindane 1 per cent) has a 40-year history, with an excellent safety record and low side-effect profile.

PERFECT PACKAGE



- Lennon Pharmaceuticals' individually blistered calendar packs contain full patient information leaflets to comply with European Directive 92/27/EEC.
- Lennon calendar packs only take a minute to dispense, saving you time.
- Lennon individual packaging helps build patient loyalty.
- With Lennon Pharmaceuticals you get exactly what you order including daily deliveries.
- Lennon Pharmaceuticals provide a quality range at competitive prices – a perfect package.

Call our Helpline on **01484 608886** for an explanatory booklet on the EC Directive.

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PHARMACEUTICALS
BECAUSE YOUR TIME IS INDISPENSABLE

LE007/95

Zantac 75 sends its season's greetings

Glaxo Wellcome's latest initiative to back Zantac 75 is an informative booklet on how to survive Christmas.

'Seasonal survival plan ... when the festivity is hard to digest' is a mix of fun and facts, with details of the key triggers of seasonal heartburn and indigestion, alongside humorous illustrations.

The leaflet will be publicised in the women's and national press and on the radio via reader write-ins/phone-ins.

Glaxo Wellcome Ltd. Tel: 0181 990 9444.

Tension mounts for Syndol ...

Syndol is currently being supported by a new consumer advertising campaign running in the women's press aimed at encouraging trial.

A range of new POS reinforces the message conveyed in the new ads. This includes window display material, incorporating a clock.

● The company has also produced a booklet, 'Understanding headaches', as well as a pharmacy assistants' training pack.

Marion Merrell Dow Ltd. Tel: 0181 848 3456.

New-size pack for Tagamet

Smithkline Beecham is introducing a 100ml size of Tagamet Dual Action Liquid to coincide with the Christmas period.

Retailing at £1.99, an added incentive for retailers is the offer of 12 free 100ml bottles with every 200ml size case ordered.

To support the launch of the 100ml bottle, a special information pack will be included in a mail shot on the new counter units. Assistants will also have the chance of winning a holiday in a special prize draw.

● SB sales reps will also be giving away 8,000 disposable cameras to assistants who quote the special Tagamet phrase when they visit their stores: "Tagamet Dual Action Liquid fights heartburn pain fast and controls acid reflux."

OTC Tagamet Information Line. Tel: 0500 100 222.

Bic offers bonus single blade

Biro Bic has introduced a '5 + 1 Free' pack promotion for Bic Normal and Bic Orange Sensitive single-blade razors.

Retail packs are clearly flashed 'Extra Free', while the packs have been kept "to size", so no change will be needed for merchandising fixtures.

Biro Bic Ltd. Tel: 0181 965 4060.

Soya, so good for long life

Granovita says that its new range of ambient-stable, long-life yoghurts is the product of extensive research. The new Deluxe Soya yoghurts come in five flavours and are suitable for both vegetarians and vegans. The 125g pots retail at £0.37.

Granovita UK Ltd. Tel: 01933 272440.

Early First Response

Carter-Wallace has updated its First Response 1 Step Pregnancy Kit as First Response 1 Step Early Pregnancy Kit and introduced the Discover 2 Home Pregnancy Test.

The updated product puts the emphasis on being an early testing kit – consumers can test on the first day of their missed period. It is available in a single or double test pack (£8.45 and £10.95 respectively).

Meanwhile, Carter-Wallace says that laboratory tests show Discover 2 to be as accurate as a doctor's test. It takes only two minutes and can be used any time of day. It, too, comes in single and double test packs (£8.25 and £10.25 respectively).

A new educational leaflet is also available, as is new point of sale material.

Carter-Wallace Ltd. Tel: 01303 850661.

Electrocute those headlice!

Following the recent furore over carbaryl, Advisa Medica is introducing Robi Comb, a non-chemical alternative to standard chemical agents to remove headlice.

The comb is not a traditional 'nit comb'. Battery-operated, its metal combing unit effectively electrocutes any present lice. Dead lice can then be removed from the combing unit with the cleaning brush provided.

Tested at the Medical Entomology Centre at Cambridge, it can be used as frequently as necessary and, since it is used on dry hair, only takes a short time to do and avoids the use of chemical methods.

It retails at £24.95.

Medilite plc. Tel: 0181 841 4144.

Another herbal mood-lifter ...

Hyperiforce is a new addition to the Bioforce herbal tinctures range.

It contains *Hypericum perforatum* (St John's Wort), *Melissa officinalis* (Lemon Balm) and *Humulus lupulus* (Hops) - herbs with a long tradition of use for anxiety, stress and sleep disturbances.

St John's Wort has recently received a lot of media scrutiny as an antidepressant following published studies in *Phytomedicine* last year. The study involved 105 patients suffering from mild-moderate depression; results revealed that 67 per cent of the Hypericum group responded positively to the treatment without any adverse side-effects.

Hyperiforce retails at £6.99 for a 50ml bottle.

Bioforce UK Ltd. Tel: 01563 851177.

Recommend them until you're sore in the throat.

Then take one.

Increased profits and fast relief for severe sore throats come from Marion Merrell Dow Lozenges. Their active ingredient, CPC, kills 99% of throat and mouth bacteria within 5 minutes,[1] giving proven rapid antibacterial efficacy tailored to your customers' needs. And as one of the most profitable lozenges in Pharmacy, they make the best use of your display space and shelf space.

Make them your No. 1 recommendation this winter.

MARION MERRELL DOW

Merocaine®

Cetylpyridinium Chloride, Benzocaine

INFORMATION FOR PHARMACISTS: ACTIVE INGREDIENTS: Cetylpyridinium Chloride 1.4mg Benzocaine 10mg. **USES:** Relief of pain and discomfort of throat infections. **DOSE:** Adults and children over 12 years: One lozenge every 2 hours as needed but not more than 8 in 24 hours. **CONTRAINDICATIONS:** Hypersensitivity to ingredients. **USE IN PREGNANCY:** No data but cetylpyridinium chloride widely used without apparent ill effects. **SIDE-EFFECTS:** Urticaria or other allergic reactions very rarely; transient burning sensation of mouth rarely. **LICENCE HOLDER:** Marion Merrell Dow Ltd, Lakeside House, Stockley Park, Uxbridge, Middlesex, UB11 1BE. **PL NOS/LEGAL STATUS/PRICE:** PL4425/0028, P, £2.15. **DATE OF PREPARATION**: August 1995.

(1) Richards, RME, Pharm. Jnl. Vol. 242 No. 6536, 3rd June 1989

POS catalogue

As part of its Goldpartners scheme, Unichem has put together a POS catalogue which includes over 15 point of sale units, including wall-mounted leaflet dispensers. Unichem plc. Tel: 0181 391 2323.

Zubes news

Ernest Jackson reports that Zubes are selling five times the volume since the brand was relaunched in September. The new-look Zubes come in foil packs and retail at £0.55. Ernest Jackson & Co Ltd. Tel: 01363 772251.

Festive Vantage

Stationery and feminine hygiene lines are among those on promotion through AAH over the Christmas period. Discount own label offers include one where Vantage members buying one of each product of Vantage Ultra Thin Towels with Wings in Regular and Super qualify for a 40 per cent discount. AAH Pharmaceuticals Tel: 01928 717070.

Ricola makes a counter stand

Cedar Health is backing its Ricola Cough Lozenges with the introduction of a new counter display unit.

The company says that tests have shown that sales can increase by as much as five times when Ricola is sold from the unit.

The stand is free of charge and has a trade price of £31.64 (plus VAT). It carries 24 of each of the 40g Lozenge packs and six packs of the 70g Original bags. **Cedar Health Ltd. Tel: 0161 483 1235.**

Fabergé moves into the Elida spotlight

Elida Gibbs is changing its name officially to Elida Fabergé from January 1, 1996.

The company says the change reflects its move towards "more upmarket brands" and to build on the Fabergé heritage. Elida Gibbs Ltd. Tel: 0171 486 1200.

Lauren luxuries in January sale

Come January, Parfums Ralph Lauren will be running special offers on two of its men's fragrances.

Available from December 26, a 59ml eau de toilette spray of Polo will retail at £17.50 (usually £27.50) and a 50ml spray of Safari for Men at £19.95. **Prestige & Collections Ltd. Tel: 0181 979 6699.**

ON TV NEXT WEEK

Clairol Ultress: G, C, A

Nurofen Cold & Flu: All areas

Nytol: All areas

Radian B: All areas except CTV, LWT, CAR & GMTV

Rennie: All areas

Strepsils Dual Action/Strepsils: All areas except C4

GTV Grampian, **B** Border, **BSkyB** British Sky Broadcasting, **C** Central, **CTV** Channel Islands, **LWT** London Weekend, **C4** Channel 4, **U** Ulster, **G** Granada, **A** Anglia, **CAR** Carlton, GMTV Breakfast Television, **STV** Scotland (central), **Y** Yorkshire, **HTV** Wales & West, **M** Meridian, **TT** Tyne Tees, **W** Westcountry

Free with Tocola

Grafton International says that sales of Tocola can be boosted by 27 per cent using its new retail display stand.

Designed to hold either the full range or a selection, it is free of charge on purchase of the full range (12 x Baking Soda Dental Floss, 12 x Tea Tree Oil Dental Floss, 12 x Tocola Stain Eraser, 12 x Plak RX, 12 x Interdental Flossups, six x Tooth Polishers with six refills).

Grafton International. Tel: 01543 480100.

World class grooming for men

Men's world hairdressing champion Craig Hubert is taking on the giants of the hair care market with his new hair grooming range for men.

Hubert feels that the emphasis on hair products to be unisex or female ranges has been going on for too long and is attempting to redress the balance with his own range.

There are seven core products in the new range: Extra Body Shampoo ($3.99), Deep Cleansing Shampoo ($3.99), Leave In Conditioner ($5.99), Structuring Lotion ($5.99), Gel ($4.99), Wax ($4.99) and Fixing Spray ($5.99).

Products are packaged in grey and black with a stylised 'CH' logo. A counter display unit and POS material are available.

John O'Donnell. Tel: 01245 256112.

Olive Oil gets her own perfume!

Popeye's girlfriend, Olive Oil, has entered the fashion world by becoming the face for Cheap & Chic, the latest fragrance from Moschino.

The red, black and white perfume bottles are based on the silhouette of the cartoon character. The scent has a fresh top note, which includes bergamot and petigrain; a floral body note; and a woody/musky base.

Cheap & Chic will be available to selected pharmacies from next spring. Prices range from £19 for a 25ml edt spray.

Aspects Beauty Co. Tel: 01273 400085.

Robitussin dose

Following the increase in the permitted levels of pseudoephedrine allowed in OTC products, dosage guidelines on packs of Robitussin and Dimotane are to change to: adults four x 10ml daily; children aged six to12 four x 5ml daily and children aged two to six four x 2.5ml daily.

Whitehall Laboratories Ltd. Tel: 01628 669011.

Natural Instincts

Clairol is supporting its demi-permanent Natural Instincts brand with a new ad campaign which incorporates a money back guarantee. It is running first in *Woman*.

Bristol-Myers Co Ltd. Tel: 01895 628000.

Gliss-ering prizes

Two Gliss hair care products have won New Woman magazine beauty awards: Gliss After Sun Intensive Care Conditioner and Gliss Cleanse and Revive Shampoo.

Schwarzkopf Ltd. Tel: 01296 314000.

RPR reassurances

Rhone-Poulenc Rorer is assuring pharmacists that it will not be seeking a GSL licence for ketoprofen (found in its Oruvail gel). "We're a pharmacy-based company and that's where we intend to stay," it states.
Rhone-Poulenc Rorer Ltd. Tel: 01323 721422.

MB up North

Molton Brown has opened a concession in the Manchester House of Fraser outlet, Kendals. It is the cosmetic house's first opening outside London.
Molton Brown. Tel: 0171 911 0070.

Lucky Dixcel dip

Over 3,000 Argos shopping voucher prizes are available to be won with Dixcel Household Towels in a current instant win promotion on specially marked packs. Vouchers are worth £5, £250 and £500, with a top prize of £1,000.
Jamont UK Ltd. Tel: 0181 864 5411.

New sporting hero

The Medisport Sportscare range is being given an extra boost with the launch of new POS material and shelf displays.

There are also two display stands, which come in two width sizes – 18 and 29in.

Ceuta Healthcare has recently taken over distribution of the range.

● According to the Sheffield University Medical School, there are an estimated 29 million sports injuries in the UK every year. Only 20 per cent of these are ever seen by a GP, which leaves more than 23m requiring self-help treatment.
Ceuta Healthcare Ltd. Tel: 01202 780558.

Bourjois' extra winter foundation

Bourjois is running a special winter consumer promotion on its Teint Lumiere foundation, giving an extra 25 per cent free in its three most popular shades.

Retailing at its usual £5.95, the three shades in the promotion are Teint de Peche, Pour Blonde and Pour Brune.

From December 27 through to February 20, Bourjois will also be offering a free cosmetic brush with any two purchases.
Bourjois Ltd. Tel: 0171 287 3051.

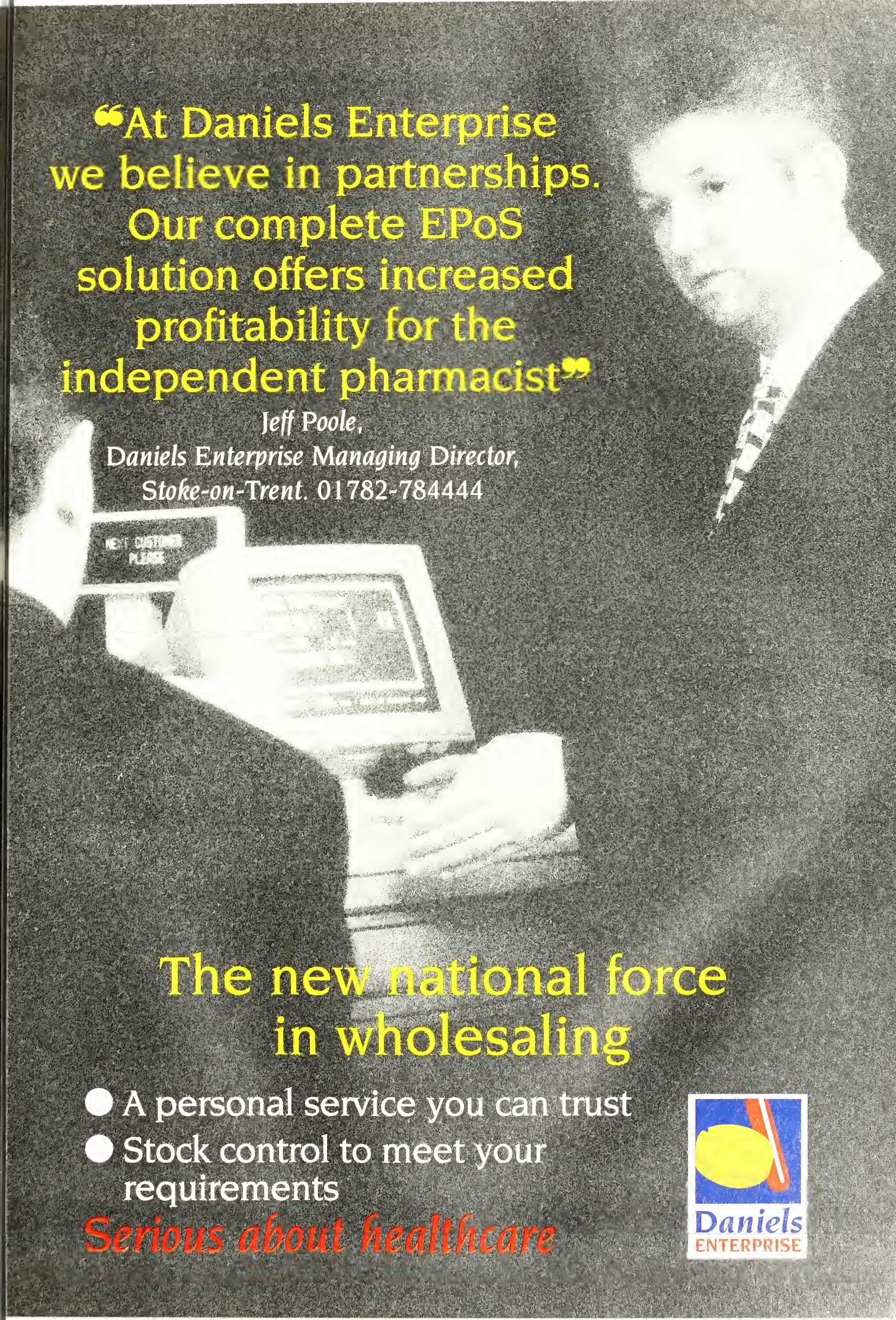
Immunace gives antioxidant boost to Vitabiotics' supplements range

Immunace is the new antioxidant supplement from Robinson Healthcare.

Part of the Vitabiotics' range, the company says the new line provides antioxidants to help protect against free radicals, with essential nutrients for the human immune system.

It contains 23 nutrients, including betacarotene (12mg), selenium (200mcg) and vitamins A, C and E, plus mineral co-factors chromium, copper and manganese, with citrus bioflavonoids and amino acids. A 60-capsule pack retails at £11.95.

An advertising support package is planned for next year.
Robinson Healthcare. Tel: 01246 220022.


"At Daniels Enterprise we believe in partnerships. Our complete EPoS solution offers increased profitability for the independent pharmacist"
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Daniels Enterprise Managing Director,
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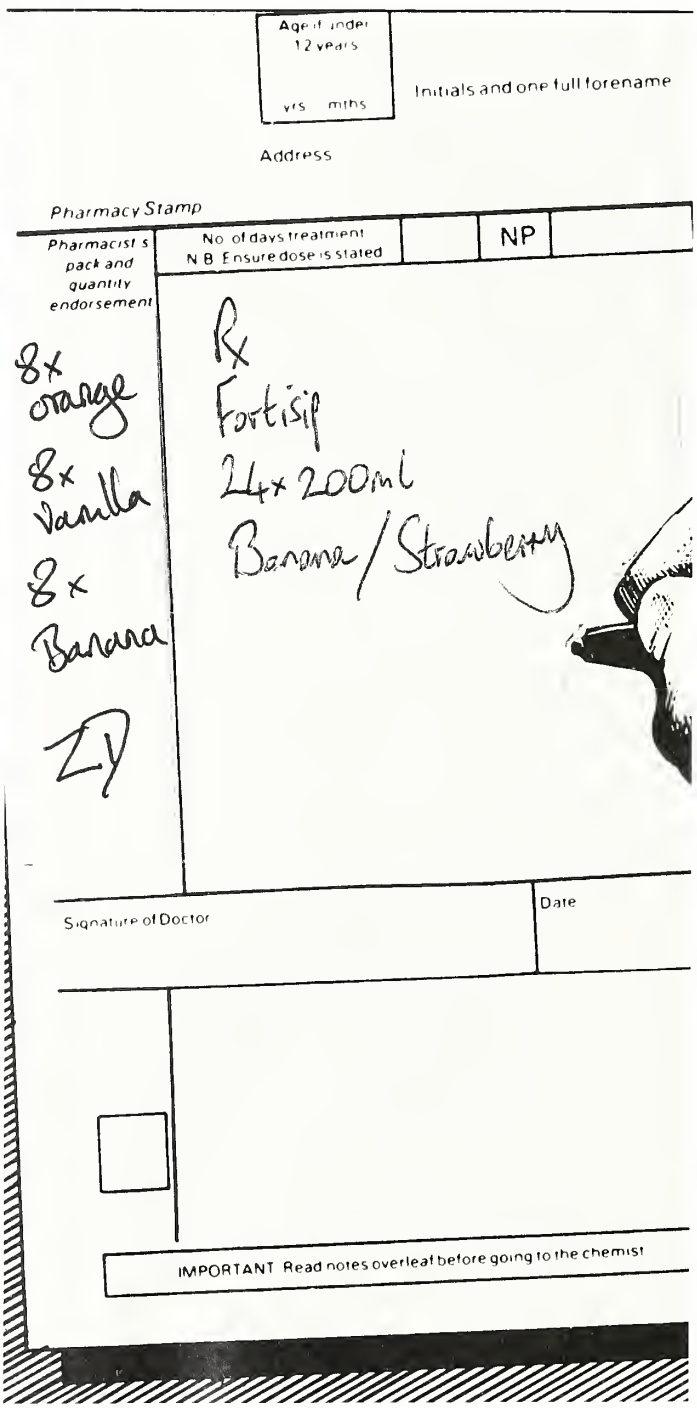
ENTERPRISE

QUESTIONS & ANSWERS

Pharmacists no longer have free rein to dispense whatever flavour a patient might ask for against a prescription where no instruction is given. The Pharmaceutical Services Negotiating Committee gives a taste of what's involved



Questions

1 Could the flavours be replaced by an alternative?

2 Can the dispensing pharmacist substitute with more flavours than ordered by the GP?

3 If no flavours are specified on the prescription, what could be dispensed?

Answers

1 Yes, the flavours may be replaced by alternatives, ie two flavours ordered, two flavours to be supplied.

2 No. The pharmacist may only supply the number of flavours ordered.

3 If no flavours are specified by the prescriber, then the pharmacists will be paid for one flavour only.

WHITEHALL LABORATORIES

CO-SPONSORED BY WHITEHALL LABORATORIES IN THE INTERESTS OF PHARMACY HEALTHCARE

CHEMIST & DRUGGIST
THE NEWSWEEKLY FOR PHARMACY

This is the sixth in a series of modules designed to accompany the Cambridge Counterpart Pharmacy Assistant Development Programme. The Programme, provided free to C&D subscribers, aims to help medicines counter assistants to reach the standard of knowledge that will be required of them by the Royal Pharmaceutical Society during 1996.

This back-up for pharmacists will enable you to keep one step ahead, so that you will know at what stage assistants are being advised to refer to you and the possible courses of action you might take.

This sixth module of the Cambridge Counterpart Pharmacy Assistant Development Programme looks at the highly seasonal problem of coughs and colds. The assistants will also be studying the related conditions of influenza, sore throats and children's coughs and colds.

In this month's Pharmacist's Briefing reference icons are used as follows:

- Refer to pharmacist
- Treatment
- Advice
- Refer to doctor or specialist
- Refer to BNF
- Information

A similar set of icons is used in the assistants' module.

COUGHS

The two main types of cough are described - the dry, irritating cough and the chesty, productive cough.

Productive coughs should not be suppressed. Expectorants may make the sputum less sticky and help it to be coughed up more easily. They should be avoided by people with stomach disorders.

Steam or aromatic inhalations made up with hot, not boiling, water may be useful.

For dry coughs, demulcents such as glycerine and honey and simple linctus are recommended, with cough suppressants advised only if the cough is a nuisance during the day or keeps the customer awake at night. Codeine tends to cause constipation and can be habit forming; pholcodine and dextromethorphan are less likely to cause these problems but should still be recommended only for short periods.

Some antihistamines are claimed to have an antitussive action and their drying effect may be useful in coughs associated with colds, when nasal secretions run back and irritate the throat. They may cause drowsiness and should not be used in glaucoma or prostate disease.

Bronchodilators are sometimes included in cough remedies. They should be avoided by people with high blood pressure or heart disease.

Some cough medicines have been criticised because they contain apparently illogical combinations, such as a cough suppressant with an expectorant. Manufacturers have argued that this combination reduces the frequency of the cough but makes it more productive, or that cough suppressants tend to dry bronchial secretions and make them less mobile, while expectorants restore their mobility. It is suggested that this is something assistants might discuss with the pharmacist.

Advice: includes encouraging smokers to stop.

Assistants are advised to refer to the pharmacist:

- **If the cough is no better after a week or keeps coming back**. The patient may have been taking an inappropriate medication, such as a cough suppressant for a chesty cough.

Refer to GP if cough has lasted two weeks or more. Persistent cough, particulary in someone over 40, needs investigation to exclude lung cancer. Dry cough may be a side effect of ACE inhibitors. Chronic cough with blood-stained sputum, night sweats and fever are symptoms of tuberculosis. Refer to GP.

- **If there is breathlessness, wheezing, chest pains or marked, unintentional weight loss**. Breathlessness could indicate chronic bronchitis, emphysema or heart failure. Wheezing suggests asthma. If severe breathlessness is sudden in onset, there may be a collapsed lung, pulmonary embolism or pleurisy. Chest pain accompanied by high temperature and blood-stained sputum could indicate pneumonia. Weight loss may be a sign of cancer or tuberculosis. Refer.
- **If the sputum is thick, yellow, dirty green or blood-stained**. Bronchitis or infection in need of antibiotics.
- **Coughs in young children**. See *later under Children's coughs and colds.*
- **People taking other medicines.** Check BNF for interactions. Antihistamines enhance the effects of sedatives and increase the anticholinergic effects of tricyclic antidepressants and phenothiazines. Avoid sympathomimetics with MAOIs and tricyclic antidepressants. Theophylline levels are increased with cimetidine, erythromycin and quinolone antibacterials.
- **Pregnant women.** As coughs are usually self-limiting, it is best for pregnant women to use only simple demulcents unless otherwise advised by a doctor.
- **People with asthma** Bronchodilators should be avoided as they may interfere with existing treatments. Night time cough could indicate poor asthma control, for which referral is necessary. Shortness of breath and wheezing should always be referred.
- **Potential drug misuse**. Some ingredients of cough and cold remedies, such as codeine linctus and ephedrine, may be misused. Assistants are advised to refer requests for excessive amounts or unusually frequent purchases.

COLDS

Assistants are advised that nothing cures a cold. Over the counter remedies can only help alleviate symptoms. The main ingredients discussed in detail are decongestants, antihistamines, analgesics and menthol.

Oral sympathomimetics should be avoided by people with high blood pressure (may increase pressure), heart disease (may stimulate the heart), hyperthyroidism (may provoke cardiac arrythmias) and diabetes (may increase blood sugar levels). Topical decongestants are less likely to cause systemic effects but should not be used for more than seven days to avoid rebound congestion.

Sodium chloride 0.9 per cent nasal drops offer an alternative where sympathomimetics are not recommended.

Antihistamines can reduce a runny nose and, by causing drowsiness, may promote better sleep.

Analgesics, which may be useful in reducing fever associated with colds, were covered in module 2.

Menthol is often described as a decongestant but it is now believed to work by increasing the sensation of airflow through the nose. It is has some expectorant action and is also thought to suppress coughs by acting on nerves in the upper airways.

Regarding food supplements, there have been reports that vitamin C, garlic and zinc are useful in colds but the evidence is inconclusive. However, the Nobel prizewinner Linus Pauling, who extensively studied vitamin C, believed the dose used in most controlled trials was too small to have a marked effect. He recommended taking 1g, four to six times daily at the first sign of a cold and continuing until the symptoms have gone. For prevention, he recommended from 500mg a day.

Assistants are advised to refer to the pharmacist:

- **People with asthma or chronic bronchitis**. Viral infections of the upper respiratory tract can trigger asthma attacks and patients may need to adjust their anti-asthma medication accordingly. Chronic bronchitics are at risk of secondary bacterial infections if they suffer from bad colds or flu. Refer to GP.
- **If colds keep coming back.** The symptoms may be due to an allergy rather than an infection. It may be seasonal, as in hayfever, or occur year-round in response to house dust mites, animal fur etc. Nasal symptoms are often accompanied by red, itchy watery eyes. People who suffer from constant colds may be deficient in certain vitamins and minerals, so it is worth questioning them about diet and recommending supplements where necessary.
- **People taking prescription medicines.** Sympathomimetics should not be used concurrently with or within two weeks of stopping MAOIs. Oral sympathomimetics should not be taken with beta-blockers, although short-term use of topical decongestants should be safe if administered correctly without swallowing the drops. See also BNF.
- **Pregnant women.** As colds are self-limiting it is best to suggest bed rest and to avoid over the counter cold remedies, although short-term use of topical decongestants appears not to be harmful.

Refer to GP

- if the temperature rises to over 40C or has been above 37.7C for more than 48 hours
- if a severe cold has not improved after a week
- sinusitis for more than five or six days
- stiff neck (possible meningitis)
- stabbing earache
- if the nasal discharge is thick and yellow or green.

SORE THROATS

Most sore throats are associated with colds, although they may be due to environmental irritants such as tobacco smoke. Because viruses are usually responsible there is little to offer by way of a cure, but customers may find some relief from throat lozenges, pastilles and mouthwashes. Povidone iodine, phenols and quaternary ammonium compounds have some anti-viral activity.

Assistants are advised to refer to the pharmacist:

- **Sore throat which persists for more than a week or keeps recurring; unexplained hoarseness lasting for a month or more.**

Ask about medicines being taken on prescription; some drugs cause bone marrow suppression, in which case refer to the GP urgently as lowered white cell counts can be serious. Inhaled steroids may be responsible; advise patients to rinse the mouth and gargle with water after use. Sore throat may also result from immunosuppression due to AIDs. A persistent sore throat in teenagers who feel generally unwell, may indicate glandular fever. Refer. Long-standing hoarseness should be referred to exclude throat cancer.

- **Sore, swollen throat with difficulty swallowing, fever and headache.** This may indicate tonsillitis or other bacterial infection in need of antibiotics. Refer.
- **Sore throat and skin rash.** This may be a drug reaction. People with glandular fever treated with ampicillin or amoxycillin sometimes develop an itchy rash all over the body. Refer to GP. These are also symptoms of childhood ailments such as measles (see later).

INFLUENZA

Many symptoms of flu are similar to those of the common cold but they are generally more debilitating and persistent. The fever is more severe and usually accompanied by weakness and aching muscles and joints.

Prevention: flu vaccination is recommended for those at greatest risk of serious complications, such as the elderly, people with kidney or heart disease, diabetes and long-standing lung disease including asthma, and those with reduced immunity due to disease or drugs. The Department of Health also recommends vaccination for people living in long-stay institutions and for health care workers.

Treatment: relief of symptoms as for coughs, colds and sore throats. Victims will probably need no persuasion to stay in bed! They should drink plenty of fluids to replace those lost through sweating.

Assistants are advised to refer to the pharmacist:

- **Flu in young children and the elderly**. Refer babies under three months. Fever in the under-fives can lead to febrile convulsions, so young children should be kept cool and given paediatric paracetamol to lower the temperature. If fits occur, they are generally harmless but children should be referred as a precaution. Both the young and old should be encouraged to drink plenty of water to prevent dehydration. The elderly are also at higher risk of developing complications. Refer if there is any professional concern.

Refer to GP

- **People with heart disease, diabetes, asthma or long-term respiratory conditions such as bronchitis.** Secondary bacterial invasion may cause more serious conditions such as pneumonia.
- **Raised temperature for more than two or three days, despite taking antipyretics.**
- **Flu in people who have returned from tropical areas in the past three months.** Possibility of malaria.
- **People with weakened immune systems, as in AIDS, or on immunosuppressant drugs.**

CHILDREN'S COUGHS AND COLDS

Assistants are advised to refer to the pharmacist:

- **Colds in babies.** Babies who are teething often suffer from cold symptoms and fever which can be treated with paediatric paracetamol. A blocked nose interferes with feeding; saline nose drops can be used to clear the nostrils before feeds and before putting down to sleep. If the baby is unable to feed, refer.

Also refer if there is severe diarrhoea and vomiting (see module 1). Chest rubs may be useful to ease congestion, but should not be placed on the baby's nostrils. Some rubs must not be used on young babies.

- **Persistent colds and blocked nose in children.** Consider an allergy, eg to house dust mites, animal fur. The obstruction may be due to enlarged adenoids which can be removed by a minor operation. Refer.
- **Coughs in young children.** It is advisable to recommend only demulcent syrups for the very young. Cough suppressants should not be used in children under one year.

If an irritating cough interferes with sleep, an antihistamine may be useful. Dry air, caused by central heating, may exacerbate tickly coughs; placing a bowl of water in the room to restore humidity may help.

Refer to GP if cough persists for more than two weeks; a persistent dry cough at night could indicate asthma. Violent spasms of noisy coughing could indicate croup or, if accompanied by a whooping sound and vomiting, whooping cough. Both should be referred.

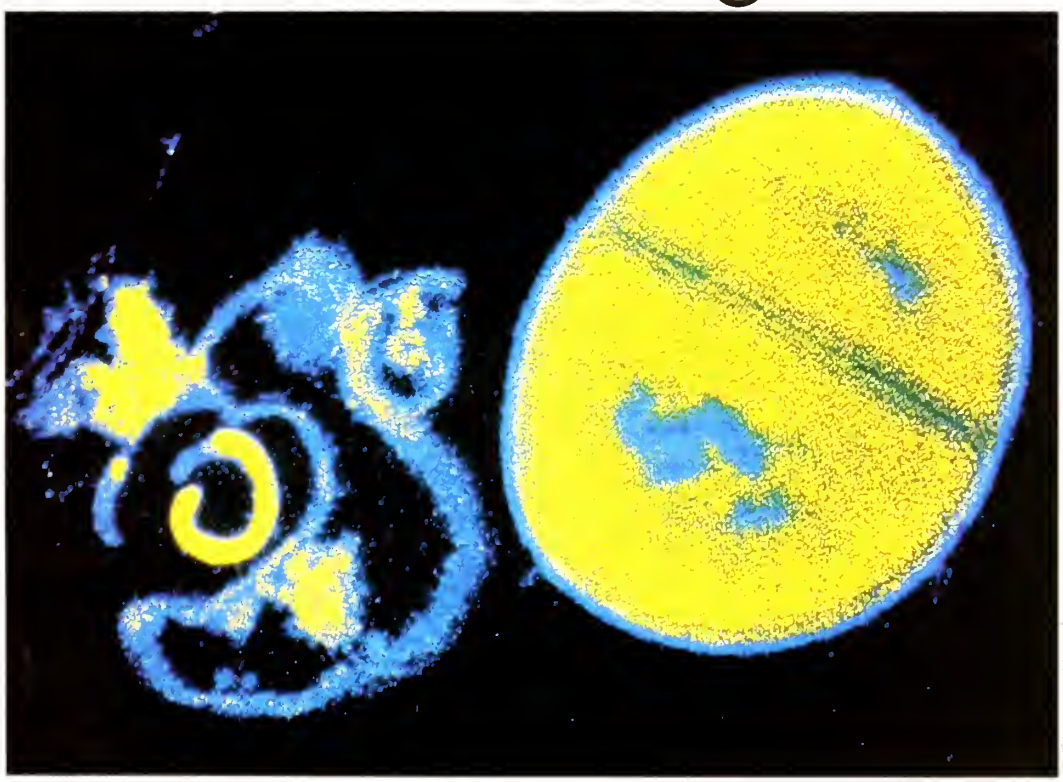
- **Sore throat and fever, with or without rash.** The measles rash is often preceded by cold symptoms and fever. If fever persists more than three or four days, if any cough worsens, if there are breathing difficulties or earache, refer. (See also under Flu referrals).

Refer to GP

- **Very swollen tonsils; tonsillitis which has occurred several times before.**
- **Sore throat which persists for more than five days.**
- **Sore throat with swollen glands in an older child.** Possible glandular fever.
- **Flu symptoms with vomiting, headache and neck stiffness.** Possible meningitis.

PHARMACY update

Resistance fighters



CNRI Science Photo Library

The *Staphyloccocus aureus* bacteria on the left has undergone lysis due to the effect of antibiotics

The fearsome prediction of widespread antibiotic resistance is not as all-pervading as it may seem. As a follow-up to his feature last month, Bayer's senior scientific relations specialist, Glenn Tillotson, sounds a note of optimism

An earlier article has described how bacteria have developed a myriad of mechanisms which enable them to resist many of our current antimicrobials.

At the recent 35th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), scientists told of an ever-increasing incidence of multi-resistant bacteria being isolated, primarily in specialist hospital units.

But, as a counterbalance to all this doom and gloom, others described some of the latest research efforts directed at developing agents which may be active against these forbidding pathogens. For the first time in years, a collection of new classes of compounds – as well as modifications of existing agents – are on the horizon.

Multi-resistance

Recent media headlines have repeatedly told of the impending dangers of multi-resistant bacteria which have been rendered impervious to antimicrobials. Attention is now focusing on these organisms where the problem is most prevalent.

● *Staphylococcus aureus*

Since penicillin was discovered in the 1940s, it has become clear that *Staphylococci* have the genetic ability to develop resistance. In the intervening 50 years, these organisms have acquired resistance to the macrolides, tetracyclines, chloramphenicol and the quinolones.

However, with the development of resistance to methicillin in the 1960s and 1970s – generally used as a last resort in the *Staph aureus* fight – the spectre of a very difficult to treat hospital pathogen has, unfortunately, become a regular visitor to UK hospitals. The epidemic strain MRSA-15, a strain of *Staph aureus* which is resistant to methicillin, has a remarkable propensity to colonise both patients and medical staff while evading many of our better efforts to eradicate the pathogen.

Presently, the only class of agents capable of predictable activity against this organism are the glycopeptides, such as vancomycin, teticoplanin and the under-development LY264826, a new alkylated glycopeptide from Lilly. This, and other glycopeptides, have been shown to be considerably more active than the established glycopeptides.

● *Enterococci*

Another spectre of gloom and doom is the multiply-resistant *Enterococci*. Of these, *Enterococcus faecium* tends to be resistant to aminoglycosides, glycopeptides, with beta-lactamase producing strains now emerging. Thus, the stock agent, amoxycillin, has been rendered impotent and there are virtually no therapeutic options now available.

Continued on PII ▶

Table 1: pneumococcal resistance

Country	Level of resistance
Japan	Penicillin resistance 20.3% of these 74% multi-resistant
Spain	Pen^R adults 4%; children 30%
Germany	Pen MIC > 2.0 in 15%
USA (Texas)	Pen MIC > 0.06 in 14%
Canada	Pen MIC > 0.1 in 10%
Saudi Arabia	Pen MIC > 0.06 in 76%

Table 2: comparative activity of new fluoroquinolones

Producer	Compound	*E coli*	*H inf*	*S aur*	*St pn*	*Ps aer*	*M cat*
Bayer	Ciprofloxacin	0.02	0.03	0.78	1.0	1.56	0.06
Daichii	Du6859a	<1.0	–	0.25	–	2.0	–
RPR	Sparfloxacin	–	0.03	–	0.5	–	0.03
Yoshitoma	Y 688	0.1	–	0.02	0.1	12.5	–
Cheil	CFC-222	0.11	–	0.2	0.2	25	–
LG	LB 20304	<0.5	–	0.06	0.06	0.25	–

– is equivalent to no data available

◀ *Continued from P1*

But, again, the new glycopeptides show some promise against these feared pathogens.

● ***Pneumococci***

During the past ten years, there has been an alarming increase in the rate of multi-resistant *pneumococci* in a number of countries.

This resistance is not confined to penicillin, indeed the *pneumococcus* exhibits resistance to erythromycin, tetracycline, chloramphenicol, co-trimazole and some latter generation cephalosporins. The range of countries and levels of resistance is shown in Table 1.

● **Other pathogens**

Other pathogens which are increasingly posing problems due to their multi-resistance mechanisms include various members of the *Entero-bacteriaceae*, *Acetinobacter* species and the 'new' beast *Stenotrophomonas maltophilia*.

So what, besides the new glycopeptides, are the pharmaceutical companies developing in an attempt to counter the growing number of 'doomsday' bacteria?

Counter attack

Other new classes include the oxazolidinones, the boxazomycins and the ketolides. Existing classes have been expanded, such as the peptidic agents and quinolones. Another option is to investigate dual action compounds, for example, combining a quinolone with a beta-lactam.

● **Oxazolidinones**

These are being developed by Upjohn and Bayer. This new class inhibits bacterial protein synthesis and is particularly active against Gram positive organisms – two compounds U 100592 and U 100766 are active against multiply resistant *Staphylococci* and *Enterococci*.

Typically, the minimum inhibitory concentration which would kill 90 per cent of *Staph aureus* organisms is between 2.0-4.0mcg/ml, irrespective of methicillin susceptibility. Similar MICs were seen with *Enterococcal* species, including those which were vancomycin resistant.

Preliminary animal pharmacokinetic studies suggest that the drugs are well distributed and there is a linear uptake in dosing.

Perhaps one of the most exciting factors associated with these new agents is their antimycobacterial activity. In the days of multi-resistant *Mycobacterium tuberculosis*, clinicians will be delighted with the potential for a new gun in their armoury. However, we still await human toxicity data for these agents.

● **Boxazomycins**

These are being developed by Parke-Davis and act on protein synthesis in Gram positive bacteria. They are excluded from Gram negative strains.

This totally new chemical class has been created following the standard structure-activity relationship analyses. MICs of 0.5-2.0 mcg/ml for *Staphylococci* and *Streptococci* have been reported.

Although these are very early data, this is another class which may be of immense importance in the fight against multiply-resistant Gram positive bacteria.

● **Ketolides**

Ketolides are a derivative of the established macrolide class and are 14-membered ring agents being developed by Roussel-Uclaf. RU708 and RU604 have activity against respiratory pathogens, such as *Pneumococci, Haemophili* and *Mycobacteria*.

Several MIC studies comparing the activity of these two agents were presented at ICAAC. They showed activity against erythromycin and clarithromycin-resistant strains. In macrolide-sensitive strains they showed slightly improved activity.

● **Quinolones**

As a class, quinolones have been around for over 30 years and in their fluorinated form for around ten years. There are around 15 fluoro-quinolones in development.

These include CP99, 219 or trovafloxacin (Pfizer), OPC 11726 or grepafloxacin (Orsuka), clinafloxacin, levofloxacin and a series of number-only compounds. While trova-, clina- and levo- are in clinical trials, the rest are running the gamut of *in vitro* and animal model tests.

These newer quinolones are more active against Gram positive species, such as *Staphylococci* and *Pneumococci*, while they often possess Gram negative activity comparable to, or less than, the existing ciprofloxacin. Due to this improved *pneumococcal* activity the quinolones are being regarded as potential saviours in the forthcoming battles with resistant *Pneumococci*.

Table 2 shows some of these new agents' activities.

● **Dual action compounds**

These have been the focus of renewed attention, particularly from Hoffman la Roche, which has developed a series of chemically-linked quinolone-cephalosporin molecules. The theory behind these hybrid compounds is elegant, however, their stability is not perfect.

Parke-Davis and Proctor & Gamble revealed novel agents at ICAAC, with typical MICs to *Escherichia coli* of 0.2 and to *Staphylococcus aureus* of 0.1-0.4. However, poor bioavailability data suggest these agents may only be administered parenterally.

● **Peptidic agents**

Peptidic agents comprise the streptogramins, such as RPR 59500 (Synercid), as well as MDL 62,879, a thiazoyl peptide which inhibits bacterial protein biosynthesis.

This latter compound has been shown to have good activity against Gram positive anaerobes, such as *Clostridium difficile*.

The other major advance in this category includes the synthetic peptides derived from Bactericidal Permeability-Increasing protein (BPI).

The Xoma Corporation has at least three developmental compounds (XMP48, XMP69 and XMP105). Two other similarly-derived compounds (XMP97 and XMP127) possess fungicidal activity.

The evidence suggests that these agents act on a totally new site and thus may have a role in treating multi-resistant bacteria.

Future for resistance

Staphylococci, Enterococci and *Pneumococci*	Oxazolidinones Boxazomycins New quinolones New glycopeptides Peptidic agents Ketolides Dual action compounds Quinolones
Pseudomonads Gram negatives	

Fungal flurry

The recent increase in difficult to treat fungal infections has prompted research into novel ways to attack fungi. Both Schering-Plough and Pfizer are investigating new azole compounds, Sch 56592 and UK 109.496, respectively.

Sch 56592 is more active than the standard anti-fungals against *Cryptococcus neoformans, Blastomyces dermatides, Candida* species and *Aspergillus* species. In animal models, it is absorbed after oral administration and shows a long half-life.

The Pfizer drug shows activity against azole-resistant *Candida* species and yields promising results in various animal models.

Other new azoles outlined at ICAAC were T-8581 (Toyama), UR 9746 and UR 9751(Uriach), ER-30346 (Eisai), DO870 (Mochida). In addition, new candidate anti-fungal classes included the echinocandin LY 303366 and Pneumocandin (Lilly), Diepoxins (Wyeth-Ayerst) and the oxidosqualene cyclase inhibitors.

Clearly, with this level of research being committed by several pharmaceutical companies, the future of anti-fungal therapy looks to have a few more options available.

And in the fight against pathogens it may well be that we are evolving from one miracle era to a period of innovation and hope. Only time will tell.

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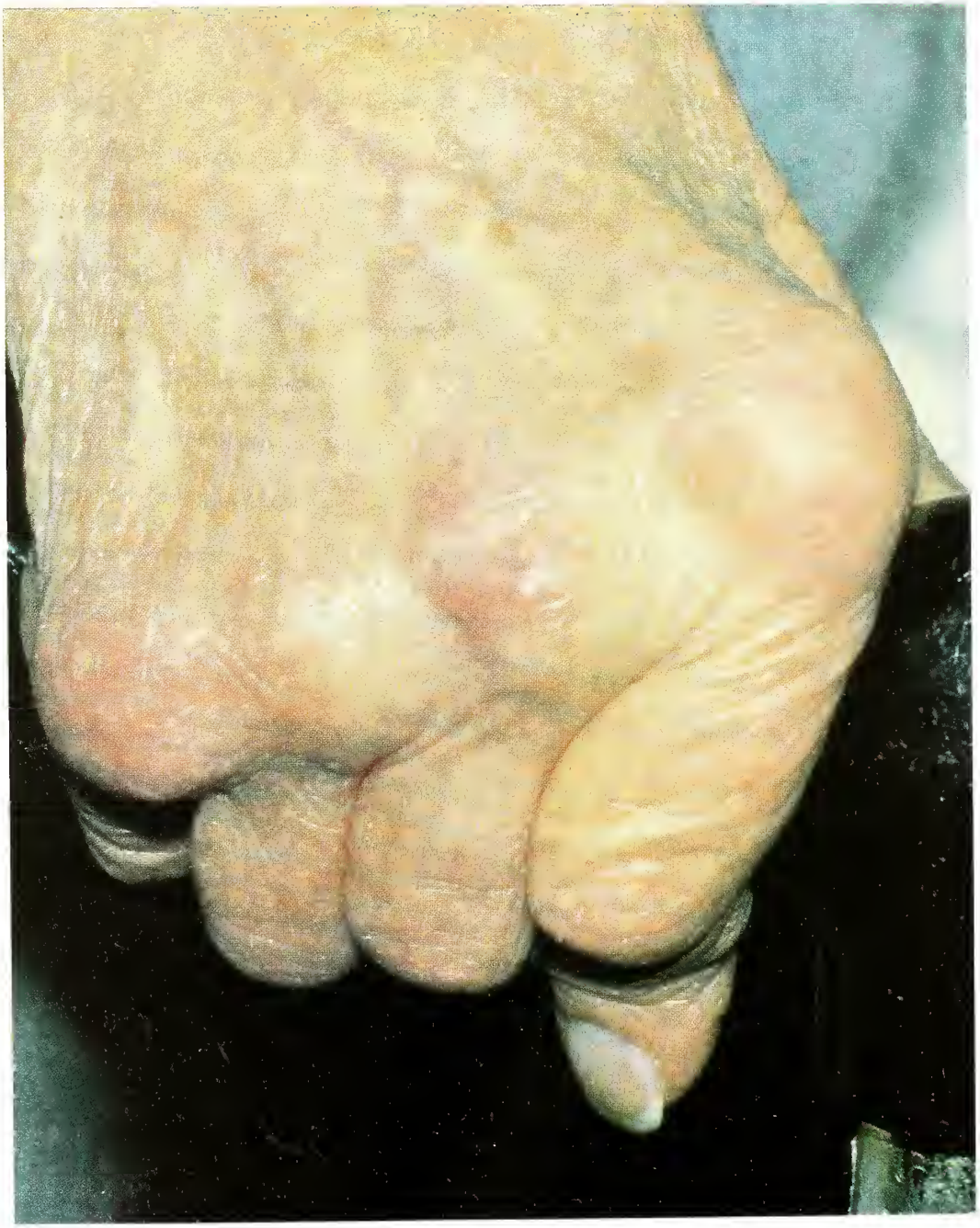
New hope for NSAIDs

The introduction of non-steroidal anti-inflammatory drugs revolutionised treatment for patients when they were introduced, but at what cost? Peter Merry MRPharmS examines promising developments on the horizon



Well over 20 million prescriptions a year are written in the UK for non-steroidal anti-inflammatory drugs (NSAIDs) – quite apart from over the counter sales – and it is well known that, while they bring significant relief to many patients, the risks of gastro-intestinal bleeding are considerable[1,2].

NSAIDs are also associated with adverse reactions in the liver, kidney and skin, but it is the gut effects which are most commonly reported to the Committee on Safety of Medicines.

It has been estimated there are some 100,000 hospital admissions due to bleeding peptic ulcers, and 2,000 perforations per year in those over 60 in the UK[3] – at an enormous physical and economic cost to individual patients and the NHS.

New research into the enzymes which control inflammation, recently outlined by Nobel laureate Professor Sir John Vane, offers considerable hope that this toll will be reduced within the next few years.

Enzyme eludation

In the early 1970s, Vane discovered that aspirin prevented the synthesis of prostaglandins from arachidonic acid by inhibiting the activity of the cyclo-oxygenase (COX) enzyme.

This mechanism was found to be responsible for the therapeutic anti-inflammatory effects of NSAIDs, but also for the side-effects of these drugs – probably as a result of suppressing the synthesis of certain physiologically important prostaglandins.

About five years ago, a number of different laboratories recognised a second enzyme which was induced in inflammation, known as COX-2.

Vane explains: "So now we have to think of COX-1 and COX-2 – very similar enzymes both forming prostaglandins – but COX-1 is constitutive. It is a housekeeping enzyme, one which has a physiological function producing prostaglandins which help to keep the stomach healthy, to keep the blood vessels clean by making prostacyclin and so on.

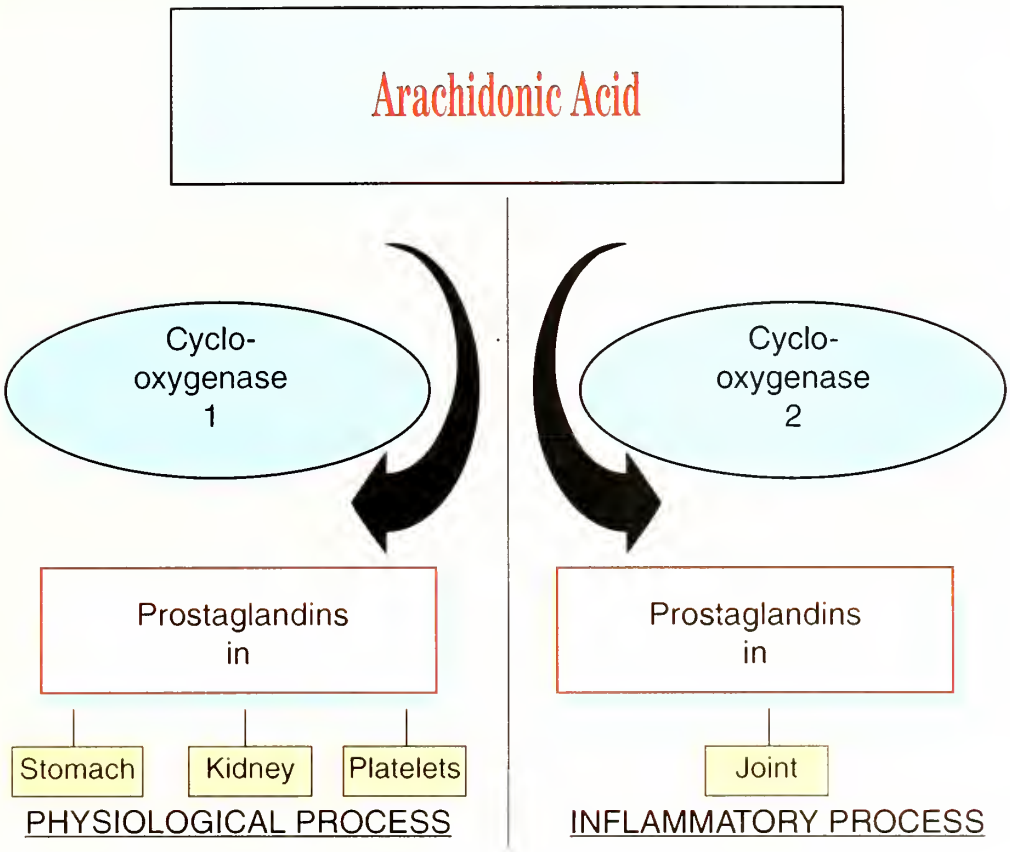
"COX-2 is not there all the time. It is only there when you have an inflammatory stimulus and it is induced by endotoxin or cytokines. That is the important one in inflammation."

The goal now, adds Vane, is to see whether just the induced enzyme can be inhibited (COX-2), without touching the constitutive one (COX-1).

Fortunately, this is possible as they have slightly different pharmacological properties and different sensitivities to drugs, "so specific inhibitors of COX-2 will be anti-inflammatory without harming the stomach".

At an international conference in London last month, further evidence was produced that the concept was solid for COX existing in two isoforms: COX-1 and COX-2. Scientists have studied different agents from the point of view of the ratio of inhibition of these two enzymes achieved.

Prototype drugs currently undergoing phase I clinical trials have very favourable ratios and therefore can be expected to have far fewer side-effects. Of the drugs which are either currently available or are approaching



availability meloxicam, which has been tested by Boehringer Ingelheim, has the best ratio from the point of view of inhibiting the two enzymes.

Side-effect profiles

The two strongest inhibitors of COX-1 are aspirin and indomethacin, the two NSAIDs which cause the most damage to the stomach. The spectrum of activities of some ten current NSAIDs against the two enzymes range from a high selectivity towards COX-1 (150-fold for aspirin) through to equi-activity on both.

It is only in the past few years that epidemiological studies of sufficient scale have been undertaken to produce hard evidence about the relative side-effect profiles of NSAIDs. Two studies[4,5] based on UK populations have produced similar results despite adopting different approaches (see table).

Based on this data, it is recommended[6] that if an NSAID is indicated, the least toxic agent should be given at the lowest effective dose. Hence, ibuprofen should be the initial choice, at a dose of less than 1,500mg per day. A group of non-steroidals, including diclofenac and naproxen, have intermediate toxicity. Piroxicam and, particularly, azapropazone stand out as being toxic to the gut.

This improved knowledge of the side-effect profiles of individual NSAIDs and the identification of selective inhibitors of the COX-2 should lead to considerable advances in the treatment of inflammation.

Patients who have little choice but to take the agents, because, for instance, of severe rheumatoid arthritis, should be able to tolerate NSAIDs better. Additionally, groups of patients suffering from conditions, such as osteoarthritis and soft tissue rheumatism, who could benefit from NSAID treatment, but are currently deterred by side-effects, could obtain considerable relief.

Another repercussion from these developments is likely to be that a number of today's NSAIDs may be superseded by a new generation of more efficacious anti-inflammatories.

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Table: NSAIDs and adverse GI reactions+

	CSM ranking	Ratio[4]	Ratio[5]
Overall		4.7	4.5
Ibuprofen	1	2.9	2.0
Diclofenac	2	3.9	4.2
Naproxen	5	3.1	9.1
Ketoprofen	6	5.4	23.7
Indomethacin	*	6.3	11.3
Piroxicam	11	18.0	13.7
Azapropazone	12	23.4	31.5

**Not ranked by CSM. Marketed before yellow card system*

+ CSM rank order of serious reports of gut toxicity per million prescriptions in first five years of marketing and odds ratio for peptic ulcer bleeding[6]

Prostaglandins glossary

Arachidonic acid
An essential unsaturated fatty acid precursor of prostaglandins and thromboxanes.

COX
Cyclo-oxygenase, enzyme responsible for the synthesis of prostaglandins from arachidonic acid.

COX-1
The constitutive isoform of cyclo-oxygenase which is present in most tissues and is responsible for the synthesis of prostaglandins. It has a 'housekeeping' function in that it regulates normal cell activity, for example, gastroprotection and the maintenance of renal perfusion.

COX-2
The inducible isoform of cyclo-oxygenase which is responsible for the synthesis of prostaglandins at sites of tissue inflammation.

Leukotrienes
A group of compounds derived from arachidonic acid.

PGE2
Prostaglandin which is synthesised via COX-1 activity and improves blood flow in the kidneys and gastric mucosa.

Prostacyclin
Prostaglandin which is inactivated by COX-1 and is involved in antithrombogenic and gastroprotective mechanisms.

Prostaglandins (PGs)
Short-lived local hormones, formed from arachidonic acid via cyclo-oxygenase activity, produced in many tissues and inducing a wide variety of biological responses including inflammation. They have effects on: acid secretion by the stomach; vascular permeability, blood pressure, platelet aggregation, body temperature; the action of certain hormones and uterine contractility.

Thromboxane (TXA2)
Lipid molecule involved in platelet aggregation, activated by COX

Coffee risk not filtered

The link between coffee consumption and increased serum blood cholesterol concentrations is well established for boiled coffee, but findings on filtered coffee, which is more widely drunk, have been equivocal.

However, recent evidence suggests coffee prepared by this method may also raise cholesterol levels. US physicians have reported an analysis of cholesterol levels in over 2,000 non-smoking coffee drinkers which gives even stronger evidence.

Healthy patients aged 25-65 attending a preventative medicine clinic were asked about coffee consumption over a two-year period; serum cholesterol was measured twice an average of 17 months apart. Most who drank coffee consumed eight to 21 cups of filter coffee per week and about one-third as many drank decaffeinated.

There was no apparent association between the baseline consumption and high density lipoprotein or total cholesterol, although coffee intake did correlate with triglyceride concentrations in men.

More interesting data emerged on closer investigation of subjects who changed their coffee intake during the study. When potentially confounding factors were controlled (eg weight, sex), a change in consumption of one cup per week was associated with a change in blood cholesterol (but not other lipids) of 0.2mg/100ml (0.005 mmol/l); a change of one cup per day was associated with a change of 2mg/100ml (0.05mmol/l).

This was true of men and women. There was also a trend towards higher cholesterol levels with increasing consumption. Cholesterol fell in the subjects who quit. By contrast, no change in lipid levels was associated with changes in consumption of tea, decaffeinated coffee or cola with caffeine.

Coffee as drunk by most people (other than instant coffee) therefore appears to have a small but reversible effect on serum cholesterol. In most people this is probably unimportant and there is no need to reduce coffee consumption. However, it may become a significant factor in those with high lipid levels and a high coffee intake.

Journal of Clinical Epidemiology 1995;**48**:1189-96

Ignorance, asthma and quality of life

A survey of 4,000 13-14-year-olds at school and 1,110 teachers in Australia has revealed that asthma commonly impairs quality of life, but there is still widespread ignorance about the disorder and its treatment.

Almost a quarter of the adolescents said they had asthma and, of these, 78 per cent said they missed an average of five days' schooling a year and 9 per cent reported using oral steroids at some time, indicating a severe attack in the past.

A quality of life questionnaire showed that asthma was associated with mild to moderate impairment in most children, but severe limitation in 22 per cent. Asthma limited participation in sports and other activities in over a third of children.

Knowledge about treatment was low among children and teachers: although 50-75 per cent knew that salbutamol is used to treat acute asthma, few were able to name three treatments useful in an asthma attack and only 3.5 per cent of adolescents with asthma and 14 per cent of teachers could name two drugs for asthma prophylaxis.

Worst of all, 42 per cent of affected adolescents and 51 per cent of teachers believed that people with asthma become addicted to drugs.

Although attitudes to people with asthma were generally tolerant, around 40 per cent of children and teachers said pupils with asthma feel embarrassed to use their inhalers in class and many felt that asthmatics exploited their condition by 'playing on it'.

Archives of Disease in Childhood 1995;**73**:321-6

Should we use newer anti-hypertensives in the elderly?

It was not until the 1980s that evidence emerged from clinical trials that drug treatment of hypertension in elderly people conferred worthwhile benefit.

As in younger adults, only the betablockers and thiazide diuretics were shown to reduce mortality – though not by as much as expected. The potential benefits of newer agents, such as the ACE inhibitors and calcium antagonists, had not been confirmed in practice.

A study from the US now shows that these clinical trials had a major impact on healthcare of the elderly. Blood pressure measurements and details of medication were obtained every three years from 10,000 residents aged 65-103 in three communities between 1982-89.

By the end of the decade, mean blood pressure had been significantly reduced and the use of anti-hypertensive drugs had increased by 14-32 per cent. This coincided with a reduction in the incidence of stroke and coronary heart disease among the elderly.

Thiazides were the most widely prescribed drugs in 1982, but, by 1988, their use had decreased by 14 per cent. The use of non-selective beta-blockers declined by 6 per cent over the same period. In contrast, prescribing of newer agents increased significantly: the use of calcium antagonists, ACE inhibitors and cardioselective beta-blockers increased by 11, 5 and 9 per cent respectively.

The use of newer drugs in the absence of scientific evidence to show that they are as effective as the older agents is consistent with experience elsewhere, the authors note.

Concern about the adverse metabolic effects of thiazides and betablockers and the apparent benefits of newer agents was sufficient to persuade many prescribers to accept the principle of treating the elderly with hypertension, but to change the means of doing so.

Archives of Internal Medicine 1995;**155**:1855-60

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Prescribing Information

Indications: For use in the relief of occasional constipation, pre- and post-operative cleansing of the bowel and prior to rectal examination. FOR RECTAL USE ONLY. **Active Ingredients**: Each 118ml (delivered dose) contains the equivalent of Sodium Acid Phosphate 21.4g (18.1% w/v); Sodium Phosphate 9.4g (8.0% w/v). Sodium content 4.4g per delivered dose. Preservatives: Cetylpyridinium chloride 0.05% w/w, Disodium Edetate 0.3% w/w. Also contains Purified Water 83.07% w/w. **Dosage**: **Adults and Children 12 years and over**: One enema no more than once daily, or as directed by physician. **Children**: Under 3 years do not administer. Over 3 years, as directed by physician. **DO NOT USE** when nausea, vomiting or abdominal pain is present, unless directed by a physician. Do not use for more than two weeks without advice from a physician. **CONSULT A PHYSICIAN** if you notice rectal bleeding, if a bowel movement is not produced after use, if the patient is on a low salt diet, is suffering kidney disease or pregnant or breast feeding. **Contra Indications**: Do not use in patients with congenital megacolon, Hirschsprung's Disease, imperforate anus or congestive heart failure. Use with caution in patients with impaired renal function, heart disease, colostomy, or pre-existing electrolyte disturbances such as dehydration, or those secondary to the use of diuretics as hyperphosphataemia, hypocalcaemia, hypernatraemia and acidosis may occur. **Interactions**: Use with caution with patients on calcium channel blockers, diuretics or other medications which may affect electrolyte levels, as hyperphosphataemia, hypocalcaemia, hypernatraemia and acidosis may occur. **KEEP OUT OF REACH OF CHILDREN**. In case of accidental ingestion or overdose, seek medical advice. Full prescribing information is available on request. PL NO 0083/0043. PA 299/13/1. STORE BELOW 25°C. DO NOT REFRIGERATE.

Product Licence Holder: **E.C. De Witt & Co. Ltd. A subsidiary of C.B.Fleet Company, Inc. USA.**

References

1. Data on file 1995, E. C. De Witt & Co. Ltd.

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Fleet™
Ready-to-use enema
Phosphate Formula

Carbohydrates the answer for PMS sufferers

Premenstrual syndrome (PMS) involves low mood, tension, irritability and food cravings. Its causes are poorly understood, though current thinking – in the US at least – is that deficiency in the function of the neurotransmitter serotonin may play a role.

There is limited evidence that treatment with the SSRI fluoxetine improves psychological symptoms of PMS and consumption of foods rich in carbohydrate may produce an improvement in mood, mediated by serotonin.

To explore whether these findings can be applied clinically, workers in Massachusetts compared the effects of a carbohydrate-rich drink shown to increase serum concentrations of the serotonin precursor tryptophan with those of a protein-carbohydrate mixture and a carbohydrate-only drink. The trytophan drink was a simple mixture of dextrose and maltodextrin; all products contained about 200 calories but the two comparator drinks did not increase tryptophan levels.

Some 24 women with confirmed PMS received each drink in a randomised order on one day in each of three separate months. Depression, anger, composite mood score and memory all improved three hours after the tryptophan drink and craving for sweet, starchy foods was reduced after 90 minutes (but not at 30 or 180 minutes). There were no significant changes after the comparator drinks and none had any significant effect on appetite.

Some PMS symptom relief is therefore possible by the relatively innocuous means of an appropriately formulated drink. The authors note the size of the benefits were small compared with those reported with drug treatment, but they add that adverse effects were non-existent.

Obstetrics and Gynaecology 1995;**86**:520-8

Diuretics, beta-blockers and sudden death

Long-term treatment with betablockers and thiazide diuretics has been shown to reduce the risk of cardiovascular events such as stroke.

One possible explanation why this achievement has not been matched by a reduction in mortality is that treatment may actually contribute to the risk of sudden death.

Dutch researchers identified 257 people who had died suddenly from a cardiac event while on anti-hypertensives. 'Sudden' was defined as death occurring within one hour of the onset of symptoms or as unwitnessed death; a cardiac cause was presumed unless postmortem evidence showed otherwise. Drug therapy was compared with that of living matched controls being treated for hypertension.

The average age of cases and controls was 74; cases tended to be slightly older and more likely to be smokers; mean blood pressure was slightly lower and they were more likely to have been prescribed combination therapy.

Adjusting for potential confounding factors, there was an increased risk of sudden cardiac death with the use of non-potassium sparing diuretics (relative risk 1.8) or betablockers (RR 1.7). The use of non-potassium sparing diuretics alone was associated with a greater risk (RR 2.2) than combined therapy (RR 1.4, not significant). Treatment with cardiac glycosides had no significant effect.

Further analysis showed that the risks were equal for men and women, but were higher within the first year of treatment and for people under 75, than for older individuals. Not surprisingly, the association between treatment and sudden death was less strong in patients with a history of heart failure, angina or myocardial infarction.

One mechanism which would explain why diuretics might increase the risk of sudden death is that hypokalaemia predisposes to cardiac arrhythmias. These may be partially reduced by betablockers, explaining the lower risk with combined therapy. However, the link between betablockers and sudden death is less easily understood.

Annals of Internal Medicine 1995;**123**:481-7

US considers flu vaccination for all

Vaccination against flu is recommended only for people at risk of complications – the elderly and those with conditions such as diabetes and asthma. But it may be logical to immunise everyone to prevent widespread suffering and economic loss.

In the US, flu vaccination is restricted, as it is in the UK, but this may change following a double-blind study in Minnesota.

In the autumn of 1994, 845 adults aged 18-64 were randomised to receive the vaccine or placebo. People who would normally be vaccinated were excluded.

During this period, 69 per cent of placebo recipients and 61 per cent of those vaccinated had at least one upper respiratory illness – a small but significant drop. However, the number of episodes of respiratory illness was 25 per cent lower in vaccine recipients, and they had 43 per cent fewer days off work and 44 per cent fewer visits to the doctor. The total number of days off work due to sickness was 36 per cent lower. The only adverse effect was local soreness in the injected arm; the frequency of systemic illness was comparable with placebo recipients.

The economic impact was substantial. Taking into account the cost of providing medical care and the work lost through illness and adverse effects, the vaccine was estimated to save $6 per person in direct costs (eg drugs) and $41 per person in indirect costs (eg work lost).

Vaccination against flu therefore benefits healthy people by reducing morbidity; and the economy by reducing absenteeism from work.

The scale of these benefits is influenced by the degree of matching between the vaccine and the prevalent virus strains, though in pandemic years the savings are potentially much greater. As flu outbreaks account for 6,000-7,000 deaths every year among 18-64-year-olds in the US, many could be avoided.

New England Journal of Medicine 1995;**333**:889-93

The cost of a GP's asthma interest

Much of the expertise in caring for particular conditions rests with GPs who have an interest in specific areas of medicine.

Research by West Country GPs and the Prescribing Research Unit in Leeds has now quantified the economic implications of specialisation in the community.

The prescribing of practices with a special interest in asthma care was compared with other practices in their FHSAs. There were no differences in total prescribing costs or number of items prescribed, but the selected practices had lower costs for drugs for infection, musculoskeletal disease and cardiovascular disease.

By contrast, their costs for inhaled beta-agonists, inhaled steroids, spacer devices and peak flow meters were higher than in the rest of the FHSA, and their costs for cough medicines and systemic nasal decongestants were lower.

The median increase in the cost of respiratory drugs prescribed by the study group was 37 per cent, but the range, from 18 to 147 per cent, reflected a countrywide variation in prescribing.

The factor most clearly related to prescribing costs was the number of nurse hours devoted to asthma: the more time available, the higher the diagnostic rates and the more prescribing.

Journal of the Royal Society of Medicine 1995;**88**:570-5

Research Digest is a regular series, written by drug information specialist Steve Chaplin MRPharmS, looking at the current developments in medicine

EVIATED PRESCRIBING
RMATION

ZEPAM ELIXIR 10mg PER 5ml

ntation: **Elixir:** clear, green lemon-mint ed sugar-free elixir containing 10mg epam per 5ml **Indications:** Short-term ement of insomnia only when it is severe, g or subjecting the individual to extreme s. **Adult Dosage:** Treatment should be as as possible with a maximum of 4 weeks g tapering off. The initial dose should be 10-5-10ml) half an hour before retiring. Dose may reased in unresponsive patients to 30-40mg ml) It should always be tapered off to suit the ual **Elderly:** 10mg (5ml) In exceptional stances the dose may be increased to 20mg **Children:** Not recommended **Contra-ations:** Hypersensitivity to benzodiazepines, respiratory insufficiency, sleep apnoea ome, myasthenia gravis, severe hepatic iency **Special Warnings and Precautions:** mitant intake with alcohol is not mended due to potentiation of sedative effect. cement of CNS depressant effects may occur concomitant use of neuroleptics, pressants, narcotic analgesics, anti-epileptics, al anaesthetics, sedative antihistamines, otics, anxiolytics and sedatives. Development of al and psychic dependence. The risk increases ose and duration of treatment, and is greater in ts with a history of alcohol and drug abuse nts should be cautioned against driving or ating machinery until the absence of hangover s such as sedation, amnesia and impaired ular function are established. The cause of nia should be sought and treated before using diazepines for symptomatic relief. diazepines may induce amnesia. Some loss of y may develop after repeated use. Treatment d be tapered off gradually to negate withdrawal oms such as rebound insomnia. Avoid use g pregnancy and lactation, unless essential **rse Effects:** Drowsiness, numbed emotions, ed alertness, fatigue, confusion, muscle ness, headache, dizziness, ataxia or double vision persist into the following day. These symptoms ominantly occur at the start of therapy. Rare rse reactions include gastro-intestinal rbances, skin rashes, change in libido, vivid ms/nightmares. Behavioural disturbances include bility, restlessness, aggressiveness, agitation, ions, rages, nightmares, hallucinations, hoses and the uncovering of pre-existing ession with suicidal tendencies. Therefore me caution should be used in prescribing to nts with personality disorders or patients with a ry of alcohol or drug abuse. Amnesia may also r **Use in Pregnancy and Lactation:** If the uct is prescribed to a woman of child-bearing she should be warned to contact her physician t stopping the product if she intends to become, uspects that she is, pregnant. If for compelling ons temazepam is administered during the later e of pregnancy, or during labour, effects on the iate such as hypothermia, hypotonia or moderate iratory depression can be expected. Infants born mothers who took benzodiazepines chronically ng the later stages of pregnancy may have loped physical dependence and may be at risk of eloping withdrawal symptoms in the post natal od. Since benzodiazepines are found in breast , temazepam should not be administered to ast-feeding mothers **Overdose:** Vomiting should induced within one hour if the patient is cious, or gastric lavage with airway protection if patient is unconscious. If there is no advantage in ying the stomach, activated charcoal should be n. Special attention should be given to respiratory cardiovascular functions in intensive care. mazenil may be useful as an antidote. **Storage ecautions:** Store in dry place below 25°C. tect from light and moisture. **Legal Category:** M CD (Sch 3) Temazepam elixir: Bottle of 300ml 95 PL 3433/0054 Unit dose 5ml x 15 £2.49 Unit e 10ml x 15 £4.98

ferences: 1. Ruben SM, Morrison CL. BJ of diction 1992, 87: 1387-1392 2. Wills S. Abuse of scribing Drugs. Pharmaceutical Journal 1993: April 537-540

te of Preparation: October 1995

mazepam Elixir is distributed by Pharmacia Ltd on alf of Farmitalia Carlo Erba Ltd, Milton Keynes, 5 8PH

ta sheet with full prescribing information available request.

rther information is available from: rmacia Ltd., Davy Avenue, Knowlhill, Milton ynes MK5 8PH. Telephone 01908 661101.

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Temazepam Elixir.

The word on the street is that it's practically abuseless.

Due to high levels of abuse, the government has decreed that temazepam capsules can't be N.H.S. prescribed after December 31st.

But, this doesn't mean the end of one of the most effective and reliable sleeping drugs available.

Temazepam Elixir and temazepam tablets are still prescribable. Temazepam Elixir is considered the least abusable form of temazepam.[1,2]

The Elixir's low drug concentration and high viscosity make intravenous abuse very difficult, whilst its high glycerol content also makes it very hard to abuse orally. Glycerol induces emesis and diarrhoea if consumed in large quantities.

So, when doctors prescribe Temazepam Elixir, ensure you have it in stock.

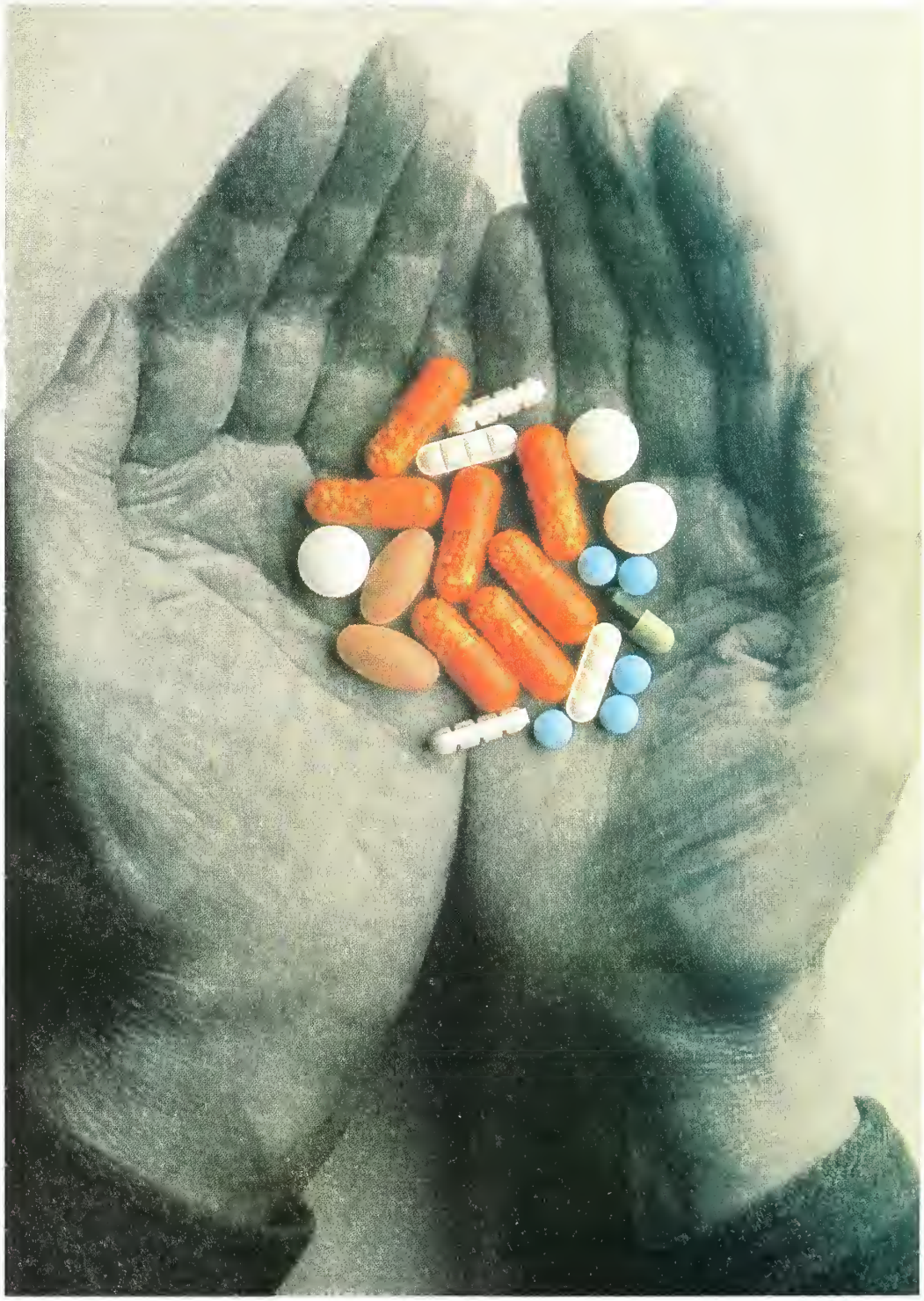
TEMAZEPAM *Elixir*

10mg/5ml temazepam INN

For a free temazepam information pack, phone 0800 262804.

Not everyone's a winne

Louise Thornton of Self Medication-IMS takes a look at the last two years of POM to P activity and suggests why certain switches have proved to be more successful than others



Thirty-one million pounds! That's the value of the OTC business in pharmacy from products that have moved from POM to P since the beginning of 1993.

The trend towards the increasingly self-medicating consumer continues, although 1995 has seen slow growth for OTC sales, with only a 2 per cent increase in value over the past year, compared to 6 per cent previously.

The table below looks at the products that have switched since the beginning of 1993, and shows them ranked in terms of sales over the past 12 months.

1	Zovirax
2	Beconase Hayfever
3	Nicorette Gum Plus
4	Zantac 75
5	Opticrom
6	Clarityn
7	Pepcid AC
8	Oruvail
9	Tagamet 100
10	Anusol Plus
11	Zirtek
12	Adcortyl
13	Optrex Hayfever
14	Hay-Crom Hayfever
15	Corlan
16	Tagamet Dual Action
17	Broleze
18	Syntaris Hayfever
19	Lanacort
20	Clariteyes
21	Anhydrol Forte
22	Regaine
23	Trosyl

The movement from POM to P status has been driven primarily by two main factors:

- various government initiatives to move substances to OTC for cost-saving reasons
- companies attempting to extend the life of brands by marketing an OTC version before the patent expires.

Keys for success

- **Market dynamics**

1 An OTC market that is not currently satisfied by efficacious products would be an attractive market for a switch product.

2 If the switch product has an additional selling point over existing products, its chances of success are enhanced.

3 To be the first entrant into a market seems to indicate increased chances of success.

- **Rx heritage**

1 If the Rx name is well established, then the chances of success are improved.

- **Efficacy**

1 A product which is highly efficacious, as endorsed by its Rx heritage, will have a good chance of success.

- **Weight of promotional spend and support**

1 A product which is well supported in terms of sales and marketing effort/spend will have an increased chance of success.

A product's chances of success are increased if it can offer a combination or, ideally, all of the above factors. Zovirax was able to fulfil all of the four key success criteria listed and, therefore, has been very successful.

Perhaps if we were to identify the key factor that led to its success, it would be that the OTC market for cold sore remedies was not satisfied with an efficacious product. Hence, the market was there for the taking when Zovirax OTC was launched.

A market that has seen significant POM to P switch activity is stomach remedies, where the H2 antagonists – Pepcid AC (famoti-

in POM to P switches

Table A: UK OTC advertising spend

Total media spend (£ millions)

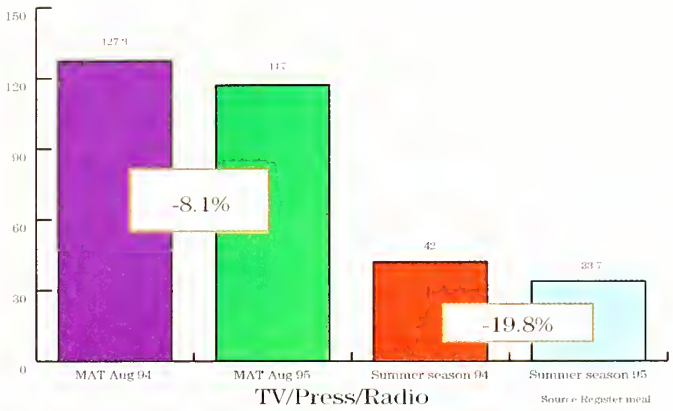
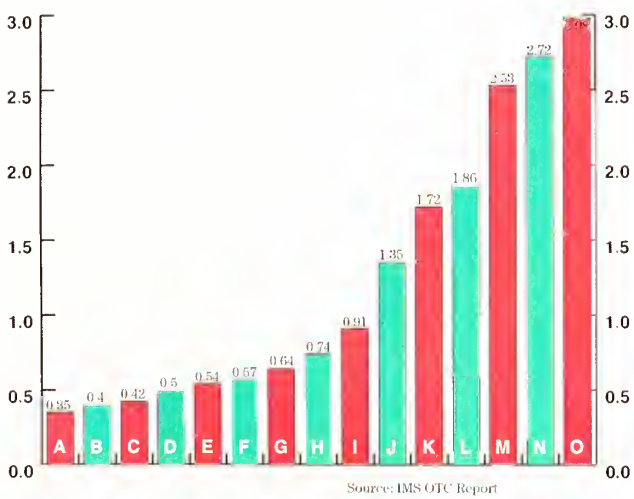


Table B: top 20 new brands in past two years

(MAT August 1995; sales £ millions)



A Junifen OTC, B Unguentum Merck C Seven Seas CLO+Garlic, D Medisense, E Relaxyl, F Bisodol Heartburn, G Medinex, H Bazuka, I Tixylix Chesty Cough, J Beechams All In One, K Niconil, L Nurofen Cold & Flu, M Nurofen Plus, N Benylin 4 Flu, O Otex

dine), Tagamet 100 (cimetidine) and Zantac 75 (ranitidine) – have all switched in the last two years.

The indications of the three H2 antagonists in the UK are very similar, all being indicated for "short-term symptomatic relief". Zantac 75 claims rapid relief, Tagamet 100 is indicated for the prevention of nocturnal heartburn, while Pepcid AC and Zantac 75 are indicated for nine hours' control of excess acid.

With similar propositions, how have the three H2 antagonist products fared in the OTC arena? The OTC antacid market has shown moderate growth over the last two years, with sales increasing by 4 per cent.

The top five products in this market have remained the same over the last two years. Zantac 75 now takes sixth position with a 4 per cent share, and Tagamet (100 and Dual Action) and Pepcid AC take a 3 per cent share each (behind Remegel and Asilone).

Overall, the H2s to date appear to have had little impact on the antacid market, which still sees Gaviscon dominant. Zantac 75 now leads in market share terms in the battle of the H2s.

Why have these products not taken a greater share of this market? It would appear the market was already satisfied with Gaviscon, which offers short- and long-term symptomatic relief. The H2 antagonists are only indicated for short-term relief and are priced to reflect this.

In terms of key factors for success, it can be suggested that the new H2s are not able to offer anything else to the consumer, over and above what is already available. The antacid market is relatively crowded, with one major player – perhaps there is not the room for anyone else?

Key players

When looking at the key players in the OTC market (see below), note that the majority are, or have been, active in POM to P switching. This in itself appears to be a key factor leading to success in the OTC market!

If we look at the market from a product perspective, the table below, showing the top ten OTC brands in pharmacy, demonstrates the success of POM to P activity. Five of the top ten are switches, previously only being available on prescription.

As well as the POM to P switches in recent years, which have provided significant revenue for the pharmacist, the last two years have provided plenty of other new products within the OTC pharmacy trade.

1 Warner Wellcome
2 Smithkline Beecham Consumer Healthcare
3 Crookes
4 Reckitt & Colman
5 Seton
6 Roche Consumer Healthcare
7 Zyma
8 Seven Seas
9 Pharmacia
10 Whitehall

The major ones listed below have generated an additional £18 million over the last year (see Table B).

1 Solpadeine
2 Nicorette
3 Benylin
4 Calpol
5 Seven Seas CLO
6 Gaviscon
7 Nurofen
8 Canesten
9 Zovirax
10 Nicotinell

Why, with all these new POM to Ps, coupled with other new product introductions, have we seen a slowing down in the growth of OTC business going through the pharmacy trade?

First, we may find a clue in that, throughout 1995, generally there has been lower advertising spend in the industry. Table A shows that the 2 per cent growth in the OTC market corresponds with a decline of 8 per cent in advertising spend. It can also be seen that there has been a marked reduction in spend over the summer, with the market witnessing a 20 per cent drop over a year ago.

As industry consolidation continues (recently Hoechst and Marion Merrell Dow, and Upjohn and Pharmacia), the market is becoming dominated by fewer and fewer large conglomerates.

These companies all have their own key brands, often leaders in their class. As this trend continues, it means that market entry costs are high, and increasing and sustained high levels of promotional spend are required for success, and future product development and innovation.

Competitive intensity within the OTC market is increasing, channels of distribution are opening up, as illustrated by the recent move of ibuprofen into the grocery sector. Is this the thin end of the wedge? What would happen if RPM was abolished?

Consumer perspective

The consumer is becoming more educated and demanding. It seems that the pharmacist has a unique offering that cannot be provided anywhere else, that of professional service and support to the consumer.

It is this key strength that the manufacturers need to be supporting and tapping into by ensuring that consumers are encouraged to ask their pharmacist for advice and providing 'Pharmacy distributed only' larger packs. This needs to be supported by adequate sales and marketing spend.

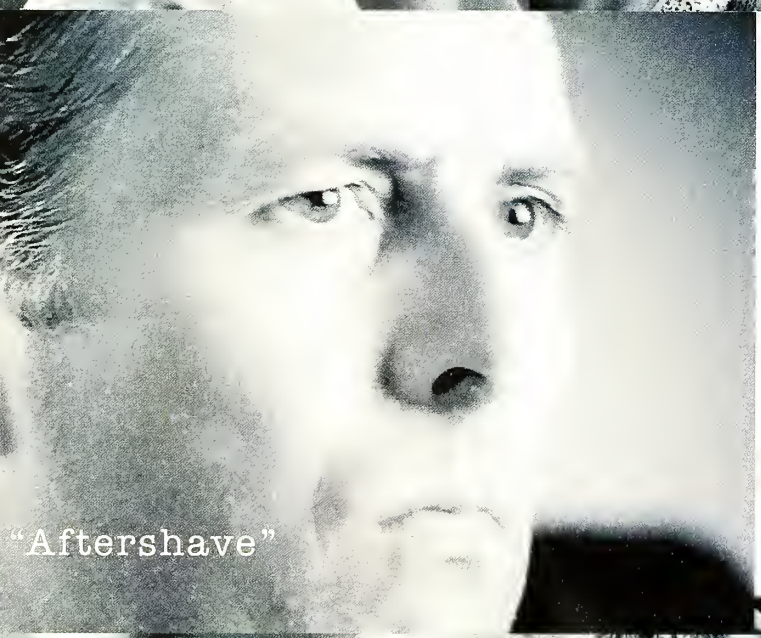
This, however, is a two-way process and the pharmacy trade needs to support the industry by effective display of products and sufficient stockholdings. Compared to last year, stockholdings are down 6.4 per cent, which could mean that some pharmacies are running the risk of going out of stock.

In conclusion, future market growth will come out of a combination of factors:

- advertising spend and Pharmacy only products to bring the consumer into the pharmacy
- professional advice and support provided by the pharmacist
- an adequate number of products displayed and stock to meet consumer demands.

Source: all data MAT August '95 at rsp. IMS OTC Report/Nielsen Retail Audit/Register Meal.

DON'T DO THAT !



ESSENTIAL INFORMATION PRESENTATION 5% w/w aciclovir in water miscible cream base. **USES** Cold Sore treatment. **DOSAGE AND ADMINISTRATION** Apply 5 times a day for 5 days. It is important to start treatment as early as possible after the start of an infection, ideally during the tingle phase. If healing has not occurred, treatment may be continued for up to an additional 5 days. **CONTRA-INDICATIONS, WARNINGS, ETC** *Contra-indications:* Zovirax Cold Sore Cream is contra-indicated in patients known to be hypersensitive to aciclovir or propylene glycol. *Precautions:* Zovirax Cold Sore Cream should only be used on cold sores on the lips and face. Do not apply inside the mouth or in the eye. Do not use for herpes infections of the eye or the genital area. Do not use if the patient is under

DO THIS !

Pump up the volume with our new pump and massive national TV support

Now there are not one but two ways to prevent a cold sore! Zovirax Cold Sore Cream is already the best selling pack in Pharmacy[1]. Now the new pump pack brings your customers the ultimate for convenience and gives you the opportunity to build on this success by pumping up your profits even higher this winter!

Warner Wellcome
CONSUMER HEALTHCARE

New controlled-delivery pump

The only product where early use can prevent a cold sore appearing

the care of a doctor because of a weak immune system. *Side and adverse effects:* Transient burning or stinging may follow application. Mild drying or flaking of the skin has occurred in about 5% of patients. Erythema, itching and contact dermatitis have been reported rarely following application. **RETAIL SELLING PRICE** *Subject to Retail Price Maintenance* 2g tube - £5.29, 2g pump - £5.99. (PL 3/0304) **LEGAL CATEGORY** P. Further information available on request: Medical Affairs Department, Warner Wellcome Consumer Healthcare, Building 29, Temple Hill, Dartford, Kent, DA1 5AH. **DATE OF PREPARATION** October 1995 BQCD 92/02. ZOVIRAX is a trademark of Glaxo-Wellcome PLC. [1]A.C. Nielsen M/J 1995

Go on, treat yourself

Encouraging GPs to recommend OTC medicines and non-treaters to make better use of them are among the approaches the Proprietary Association of Great Britain is using to encourage positive self-medication

Sheila Kelly: pharmacists have a key role in PAGB plans for OTCs

We are moving into a different era of self-medication, says Sheila Kelly, the director of the Proprietary Association of Great Britain. "Signs of this are beginning to appear. We have been beavering away to get products deregulated for existing conditions. Now we are looking for new indications."

But she is also aware that an astonishingly high proportion of people still use nothing at all to treat ill health. PAGB research in 1987 showed an average of 45 per cent were non-treaters, although treatment levels varied dramatically depending on the condition.

Focus group research done by the PAGB suggests consumers are good at treating themselves, provided they are confident of the source of their illness. They will not treat when unsure. There is an educational job to be done, says Ms Kelly.

To help on this front, the PAGB has produced a patient video in conjunction with the Royal Pharmaceutical Society, putting across the message that there is no point in soldiering on unnecessarily. 'Do not go to the GP for minor ailments. Self-medication is part and parcel of taking care of yourself'. Copies have been sent to all Society branches.

Following POM to P switches, doctors are also beginning to realise that, with conditions like hayfever, they haven't got anything better to prescribe. For these conditions, recommendation by GPs to purchase OTC is increasing, especially if they are aware the patient has to pay a prescription charge.

The PAGB is keen to see the message to make better use of medicines coming from pharmacists and doctors. "Patients are quite cynical about industry promoting greater usage of medicines," says Ms Kelly.

With this in mind, the PAGB has got together with a group of family health services authority medical and pharmaceutical advisers to produce a resource pack "to turn GPs on to OTC recommendation". It is being piloted in 12 FHSAs and should be ready for a national launch early in 1996.

The PAGB is hoping FHSAs will offer GPs training courses run by pharmacists. The Association is bearing the cost of the pack, which is built around individual case studies.

Ms Kelly says that, for the past four years, the PAGB has had a strategic plan for OTC medicines, with the pharmacist playing a key role. While the Nuffield report focused on an extended role for pharmacists within the NHS, the OTC business was taken for granted. However, the industry now "has the feeling that we are getting a very positive reception from the pharmacy side", she says.

She is reasonably happy with the mechanism of the switch process itself. But companies need a better understanding of what data is required to initiate a switch, she feels. More information on the pattern of how a condition is managed, and how GPs handle diagnosis, might help the expert committees understand "where a company is coming from", suggests Ms Kelly.

It would also help if patient information was submitted with an application, to help build confidence in the application. Applicants are encouraged to talk to the RPSGB for advice on how to educate the pharmacist, who may well be initiating treatment with a novel OTC molecule.

> Patients are cynical about the industry promoting greater use of medicines

Collaboration

After the success of POM to P switches in recent years, self-medication is poised to expand into new areas, Ms Kelly suggested at a recent conference.

She said shared care of patients between doctors and pharmacists using non-prescribed medicines is the way ahead in two areas:

- recurrent illness which needs initial diagnosis, but which is subsequently recognised by the sufferer
- chronic illness which can be managed by OTC medication unless the condition worsens.

Conditions which may be suitable for collaborative care include:

- irritable bowel syndrome
- blood lipid lowering
- hormonal contraception
- treatment of arthritic pain (under discussion with the DoH)
- treatment of eczema (now an OTC indication).

The Royal Pharmaceutical Society is thinking along similar lines. The second section of it most recent POM to P recommendations lists seven lines, including hormonal contraceptives, it considers suitable for Pharmacy sale after initial medical diagnosis or examination.

No P to GSL agenda

The PAGB does not have a P to GSL agenda. The Medicine Control Agency's timing could not have been worse from the PAGB's view, says Ms Kelly.

When the Medicines Act 1968 was introduced, medicines on both Prescription and General Sale List medicines were reviewed, but not the Pharmacy category, which fell between the two. The PAGB has never asked for a review, but companies are now looking at P to GSL, "especially since ibuprofen is not an insignificant move".

In the manufacturers' view, the advantage of GSL lines is that they can go on open display. "If P to GSL results in a growth in the market, there will be interest. If it just results in a change in brand share, then there will be less," opines Ms Kelly.

High-dose aspirin became GSL a couple of years ago through the same process, and no one batted an eyelid when it happened, she recalls.

While the Society argues for consultation before any switch is made, Ms Kelly takes the opposite view: "I don't think there should be any consultation on switches. In POM to P situations it has meant people could piggyback on the innovators.

"The waiting period allows competitors to improve existing lines, prepare advertising campaigns ... a whole six months to build up brand strengths. It is hard to justify it being for public safety issues. Responses are few and usually from bodies already represented."

Ringing the changes

With the POM to P switch process well established, both professional and industry bodies are looking to take the next step ...

Four years ago, almost as an afterthought, Roger Odd, the head of the Royal Pharmaceutical Society's practice division, speaking at an industry seminar, put up a list of 51 possible POM to P switches.

The interest, he recalls, was immediate, and has lasted to this day. "Companies came to us in a steady stream." It is one of the few areas where OTC manufacturers and the pharmacists' professional body find they share a common goal.

More recently, the Society has published a second, shorter list, which could turn POM to P into a whole new ball game. The list comes in two parts: the second includes products which could be made available from the pharmacy after initial diagnosis and treatment by a GP.

Mr Odd uses hormonal contraceptives as an example. "Single-hormone contraceptives have a good safety record. We feel treatment could be maintained by a pharmacist. In the main, the medical profession is quite supportive of the fact that pharmacists have a role in repeat prescribing. There needs to be adequate reference back to the GP if there is a problem. Pharmacists also need to recognise the limit of their knowledge."

This evolution of POM to P into a repeat prescribing function carried out within pharmacies raises all kinds of interesting possibilities at a time when the professional boundaries in many areas of primary care are becoming increasingly blurred.

While the Society's first list was drawn up mainly for internal use and without consultation with other bodies, the second appeared after consultation with the Medicines Control Agency.

"Changes were made as a result, but it is not an approved list in the true sense of the word," says Mr Odd. "Companies still need to go through the consultation procedure. The MCA has not given wholehearted support to all the products on the list."

Looking back ...

The RPSGB, in the wake of the Nuffield Report, had become deeply interested in the POM to P process (or, rather, the lack of it at the time). In 1989, after discussions with the Medicine Control Agency, two switch applications were put in by the Society, one for imidazoles for vaginal thrush and the other triamcinalone for mouth ulcers.

"The latter was rejected," Mr Odd recalls. The amount of work involved in preparing the applications was immense, since the RPSGB did not hold a lot of the safety data and had to make its own case.

By 1992, the MCA had established the fast track POM to P switch process. With twice yearly opportunities for submissions (January and July), it still takes a year to get through the process.

A professional body can still put in an application under this process, says Mr Odd, "but our view after the imidazole experience is that it is more appropriate to encourage individual licence holders. They have the data at their disposal and they are more likely to support the product when they are the instigators of the process."

However, there are still a lot of ethical companies whose regulatory affairs people are not certain of the procedure, he believes. Pharmacists, too, have got the wrong idea in some areas. He cites Schering's PC4 – the morning after Pill. Despite the debate, Schering has not made any move towards POM to P. The company is still considering whether it should make an application.

"The concensus within the professional bodies is that it should be more widely available," says Mr Odd, "but it is not a universal opinion. There are concerns on moral grounds, and also whether pharmacists are capable of supplying emergency contraception.

"The majority of pharmacists say that it should be more widely available and sold under a protocol. This might be a situation where the Society would actually lay down a protocol."

A great benefit

A great benefit of POM to P, feels Mr Odd, is that the industry has realised it can work closely with the professional body. "We can review applications and suggest ways that training needs might be arranged for pharmacists."

It is unusual for the Society to build this kind of rapport with industry. In the last year it has led to two companies being advised that their application for a POM to P switch needed to be reconsidered. "The last thing we want to see is deregulated products losing their market value and being stuck in the back drawer," explains Mr Odd.

He also claims the Society will follow up companies which have potential POM to P switches and ask what their intentions are. "The Society has established its credibility in this area," he avers.

There are a number of applications to the MCA which have been rejected or deferred, although in such cases only the applicant will be aware of the precise situation. And while some manufacturers try to launch their brand onto the market when the regulations come into effect, an increasing number hold back. But if a compound has switched, you can be sure at least one company has put in an application.

Roger Odd believes in evolution

The UCA and Glaxo – friends or foes?

I wish to express my thanks for the compliments and criticisms voiced in the **Northern Ireland Notebook** of November 4. The compliments are undeserved. If the Ulster Chemists' Association has made an impact and found favour, the credit must lie with the Executive Committee and members, who have demonstrated their dynamism and the need for both imagination and radical thinking in meeting the challenges of our profession in present times.

The criticisms are actually more welcome, since it is from criticism that we learn most. I would agree that the majority of small contractors in Northern Ireland are disadvantaged by the present Glaxo discount scheme.

The large accounts and chains are probably doing better since there are special discount rates for large volume. This is, of course, true of all drug supply in that the more you buy the bigger the discount. Indeed, if you are a sharp negotiator, you always get a better deal, even negotiating away the wholesaler threshold in some instances.

The UCA Executive has made numerous representations to senior management at Glaxo since the agency scheme was introduced. We have opposed it vociferously and tried to negotiate different discount arrangements to reflect the much larger number of small contractors present in Northern Ireland compared with England, Scotland and Wales.

During those negotiations, we were invited by Glaxo to put forward for Glaxo support projects which we thought would benefit our members. The company's position was that the agency scheme was here to stay, but it wanted to work with community pharmacists.

The scheme has failed in terms of getting closer to customers, and your comments tell us that the sponsorship we have received in the past two years has done nothing to change that.

We have two options open to us. We can refuse to co-operate with Glaxo and continue to voice our opposition. That has failed in the past, and if we choose that option, we must have some new ideas as to how we can make it work.

The second option is to work with Glaxo and use its expertise and money to the benefit of our members. Your comments tell me that has also failed.

I chose that option and its failure may be down to the fact that myself and the Committee were not sufficiently ambitious or imaginative. If even half the money you estimate has been taken out of our discounts by Glaxo, then there is plenty left.

Why not ask the company to pay the salary of a pharmacist employed to progress community pharmacy practice in Northern Ireland? Could Glaxo finance our audit facilitator for a third year?

The Ulster Chemists' Association is firmly committed to supporting the independent pharmacist in Northern Ireland and will continue to do so in the future.

We will always say 'thank you' for support: after all "manners maketh the man" (or woman).

Sarah Mawhinney
President, Ulster Chemists' Association

DoH should bring in 5km limit for rural dispensing

Interprofessional co-operation between pharmacists and doctors is obviously in the patient's interest. The Samson and Whitefield fraud case near York (*C&D* October 7 and November 4) brought both professions into disrepute.

Cosy relationships and monopolies were warned against in the recent reorganisation of the Health Service. There will be conflicts of interest, and previous generations made a clear division between prescribing and dispensing. It should be self-evident to those who would encourage the ultimate monopoly of doctor dispensing, when no other person is involved in the process, that it should only be allowed in extremely rare instances.

The extension to five kilometres of the distance patients have to live from a pharmacy, as is proposed in Northern Ireland, should be implemented as soon as possible in the rest of the UK. The Department of Health should review the regulations for rural dispensing and ensure that conflicts of interest are minimised.

R N Thomas
Holyhead

Calling employee pharmacists in Hampshire

In common with a number of other LPCs, primary and secondary healthcare in Hampshire will be administered by more than one health authority from April 1, 1996. This necessitates the formation of new LPCs which, in Hampshire's case, will be: North & Mid-Hampshire, Portsmouth & South East Hampshire, and Southampton & South West Hampshire.

The major problem that LPC secretaries have when it comes to electing new committees is the identification of all employee pharmacists.

May I, therefore, through your columns, ask that any pharmacist employed in community pharmacy, including locums who work for an average of not less than eight hours a week, who do not fall into the independent contractor or CCA/Co-op groups, and who wish to be included in the Employee Pharmacists' Register for these three new health authorities, identify themselves to me as soon as possible.

Would they please send a note of their full name, address and contact telephone number, together with the name of the area within which they principally work to me at the address given below, before December 9.

I must stress that, whereas we are not looking for nominations for the new LPCs at this stage, anyone who is not included in the Register will not have a vote and neither will they be eligible for nomination.

May I also ask readers of this letter to bring it to the attention of their employee pharmacists and locums and to urge them to register.

Jeff Holloway
Secretary, Hampshire LPC, 2 Church Street, Romsey, Hampshire SO51 8BU

Letting off steam ...

After reading Dr Maguire's comments at the Numark conference, I can't help wondering whether we are meant to be pharmacists or wet nurses!

Suddenly we are supposed to abandon supply of drugs and OTC medicines and place that in the hands of an unqualified individual who, because of attending a few training courses, is quite capable of dispensing medication safely while we are playing doctors and nurses. Wake up, man!

It's all very well for Dr Maguire to talk about our new monitoring role, but there are a few obstacles on that path.

- The public perception of screening and monitoring is that this is a job carried out by a doctor, not a pharmacist.
- Who will pay for this new role? The Government? Forget it! The patient? Yes, but at what price? Unemployed people will not pay for this service and that's a fact.
- Our insurance for professional indemnity is very high as it is. How much more would be added on with the additional risk factors of both the new monitoring role and the inherent danger of losing focus on the main aspect of our business, ie dispensing.

Suggestions have even been made that two pharmacists would be required to operate this service. Paid for by whom? The Government? Get real!

I strongly disagree with Dr Maguire that the era of pill and potion makers is gone. I'm still one, and very much embrace many of the old remedies. I am confident that I have much better success with these types of preparations than with the 'new age' drugs. The financial reward far outweighs that from a monitoring role.

I love Dr Maguire's optimism. For a long time now he has been beating the 'justification for more remuneration' drum. Unfortunately, the powers that be still have their ear plugs in.

There is one point with which I do agree with Dr Maguire, and that is the fact that many of our retail outlets do resemble bazaars.

Unfortunately, we don't seem to have grasped the fact that we are stocking items which can be found in any supermarket, and if we wish to remain competitive, we must take a reduced profit margin.

Certainly I agree that we should, as a profession, move into the area of healthcare centres, but not to the exclusion of what our purpose really is, ie dispensing chemists.

We must consider the possibility that there is reasonable justification for the Government to further reduce dispensing remuneration if it is carried out by trained technicians.

Now I've had a good moan I feel much better.

John G Fleming
Whitehead, co Antrim

Astra group boosts R&D drug pipeline

Swedish drugs group Astra plans to step up research and development expenditure.

The company told analysts at a research and development update meeting that it intends spending around 15 per cent of sales on R&D and, although it will look at new collaborations and acquisitions in the future, it is likely these will involve specific projects rather than whole companies.

Astra also outlined how it will integrate Fisons' R&D operation, acquired in March for $202 million. Hakan Mogren, Astra's president, said the acquisition provided "a new base of competence and research capability, and also a product portfolio".

Several of Fisons' compounds have entered the Astra R&D pipeline, and the purchase has also boosted existing research areas and given the company access to leading non-CFC aerosol technology.

Astra "has never been in such a strong position in R&D", said the company's vice president Claes Wilhelmsson.

To complement its blockbusting ulcer drug, Losec, Astra is working on formulations for acid inhibition and *Helicobacter pylori* eradication. Mosapride, licensed from Dainippon in 1994, is in early clinical trials and could be used for dyspeptic symptoms.

In CNS research, Astra has several drugs emerging. The stroke treatments clomethiazole and ARL 15896 have enormous potential markets. There are currently no treatments for stroke and Astra believes its research is "ahead of other companies". Clomethiazole has shown good results in clinical trials.

Remacemide is undergoing phase II clinical trials in patients whose epilepsy is not controlled by currently available drugs and results suggest that it may have a neuroprotective effect.

Astra is also developing NXX-066, an acetylcholinesterase inhibitor, to improve learning and memory in Alzheimer's disease and believes that, although several companies are working on drugs for dementia, it is in "a good competitive situation".

Astra president Hakan Mogren: Fisons buy boosts portfolio

It is also focusing on thrombosis treatments. Two fibrinolytic/-thrombolytic agents are in phase II trials and a Fisons' antiplatelet drug is in phase I clinical trials.

All the company's new asthma treatments will be developed as dry powders for the Turbohaler, as well as in MDI form. Astra believes that its Formoterol Turbohaler, being developed to complement its inhaled corticosteroid therapies, could become one of its best-selling products.

Multiples remaining active in the market

Large pharmacy chains and supermarkets are becoming increasingly active in the market, according to the Royal Pharmaceutical Society's register of premises.

October's changes bring the total number of pharmacies on the register to 12,143. Multiples accounted for almost half the 160-plus registrations, sales and transfers of pharmacies, with Superdrug leading the field.

The High Street druggist, which has a target of 40 pharmacies by next year, chalked up 18 transactions, which included six acquisitions from independents. Boots and Lloyds were also active in the market, acquiring ten and six outlets respectively.

Tesco was the most active supermarket, opening six pharmacies. Sainsbury, which announced its pharmacy initiative earlier this year, opened for business in Cheadle, Cheshire, and bought another in Manchester.

Overall, 17 pharmacies were deleted, with the South losing the most: six going in London, the Home Counties and the South East. There were four deletions in the North East, two in East Anglia and one apiece in the Midlands, Scotland and Wales.

Some 37 pharmacies commenced trading and registration was approved in 55 cases.

NPA rolls out new credit card handling deal for '96

The National Pharmaceutical Association is to introduce a new credit card handling deal in the new year. Because of the difficulty in getting the new deal up and running before the busy Christmas period begins, it will be promoted early in 1996.

Around 1,000 members currently arrange card handling through the NPA. It is easy to transfer from an existing supplier, says NPA business services manager Trefor Williams, and, contrary to belief, businesses do not have to use their own bank as a service provider.

● Meanwhile, Switch, the UK's leading debit card, is launching a new campaign to encourage cardholders to use it as an alternative to cheques and cash.

The 'Dough, Dough' campaign

There are around 14.7 million Switch cardholders in the UK and some 200,000 retailers are signed on to the scheme. Switch hopes that the campaign will not only increase the use of the card by consumers, but will also attract retailers who are still assessing the benefits of the scheme.

Commenting on this development, Mr Williams told *C&D* that providing credit and debit card facilities for customers is up to individual members. However, he advised that pharmacists should weigh up the difference that credit and debit facilities will make to turnover and the expense involved in providing the service for consumers.

With a debit card like Switch, which charges a fixed fee per transaction, a pharmacist could lose up to half his profit when a customer pays for a prescription.

Switch's latest campaign – Dough, Dough – aims to show how outdated cash has become.

VAT alert

Pharmacists in the Midlands, using the retail VAT scheme B, are being targeted by Customs & Excise inspectors, warns the NPA. Many pharmacists use their wholesaler statement to identify zero rated lines, but this could include prescription items which should not be uplifted. As a result, businesses could be overclaiming VAT. Only zero rated sales through the till should be uplifted, or a special 'NHS factor' applied.

GW tax loss

Glaxo Wellcome has lost a High Court ruling in favour of the Inland Revenue. Tax authorities now have the power to investigate transactions by Glaxo companies before 1986.

Boots loyalty card

Boots is trialling a customer Advantage Card scheme in 13 stores in the Norwich area. The card can be used to obtain one point for every 10p spent in the company's outlets. The points cannot be used against prescription medicines, vitamins or other supplements. The scheme will be trialled until October, 1996.

Culmak sale

The shareholders of Culmak, the shaving brush manufacturer, have bought the business from baby products manufacturer Maws. The new firm has recently won a contract that has boosted Culmak's own-label manufacturing to 60 per cent of the business. John Chapman has joined as general manager.

Jackel buys Maws

Jackel, the manufacturer of baby accessories, has acquired the Maws Group. Business will continue as usual for Maws' customers and the 35-strong workforce at its Stevenage headquarters will remain in situ.

BASF Q3 results

The German chemicals group BASF saw third quarter pre-tax profits of DM1,071 million, more than double those of the third quarter of 1994. However, sales remained almost static at DM11,846m for the quarter. The former Boots' pharmaceutical operations contributed DM280m.

BOC results

BOC Group reported record pre-tax profits of £402 million, up 13 per cent. Turnover was up 8 per cent to £3,752m. Operating profit for BOC gases was up 13pc.

Hills MD joins main AHH board

Michael Major, managing director of the Hills' pharmacy chain, has been promoted to the main AAH board.

The move was made in order to boost retail representation on the company's main board. Until now Mr Major, who officially took over from Allan Orme last month, was reporting directly to the parent company, Gehe, in Germany.

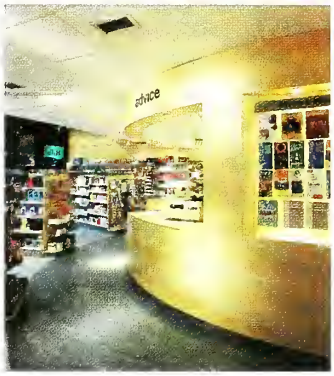
The Hills' chain of pharmacies, operated by AAH, was earmarked for expansion by Gehe chairman Dieter Kammerer when he acquired the UK wholesaler after a hostile takeover battle earlier this year.

Mr Major says that most acquisitions since the takeover have been small, apart from the 35-store northern chain Medimart in August. Acquisitions will continue, but he maintains that there are no set targets for expansion.

The company has formally restructured, splitting its retail and NHS functions.

Its superintendent pharmacist, Nick England, who was formerly responsible for all retail business, will now concentrate on the NHS side. In addition, Alan Sanders, who has worked for the Forbuoys newsagent chain, has been brought in to beef up the retail side.

Hills' outlets are also undergoing a redesign. Mr Major stresses that it will be a slow process, as the stores will not take on a uniform appearance, but will reflect their locations, depending on whether they are on the High Street, in local shopping areas or near health centres.



Six Hills' outlets have been refurbished, including Sowerby Bridge, Yorkshire

Pharmaceuticals make a billion

The UK's positive trade balance in pharmaceuticals has jumped to more than £1 billion for the first six months of the year.

The positive trade gap grew to £1,058 million compared to £851m for the first half of last year, according to figures from the Association of the British Pharmaceutical Industry.

Although imports grew (up £1,373m compared to £1,084m last year), the value of exports rose even more, from £1,935m to £2,431m for the first six months. Dr Trevor Jones, director general of the ABPI, describes the figures as "extraordinarily impressive".

Elsewhere in Europe, Germany moved from a deficit of £21m to a surplus of £29m.

Hadley Hutt teams up with software group

Pharmacy computer firm Hadley Hutt is to join forces with software company MKA, which supplies local authorities.

The companies will operate separately, with ownership vested in a holding company, MKA (Holdings), of which Mike Hadley becomes a director. He remains chairman of Hadley Hutt, while MKA chairman Tony McDowell is managing director.

The deal should release resources to develop the PILLS PMR system and the POSHH Checkout EPoS package. Hadley Hutt's hardware division will expand to supply to MKA customers.

Sales rise at the pharmacy

Pharmacists saw a marked rise in sales in October and business was above average for the time of year, according to the CBI's Distributive Trends Survey. It is the third successive month that pharmacists have seen a rise in sales.

The sector reported one of the highest annual growth rates of any retail area, with sales volumes up 51 per cent. Only booksellers and stationers reported higher annual growth in sales volume (up 61 per cent). Pharmacists' sales for the time of year were up 20 per cent on 1994.

The CBI survey predicts that volumes will rise further, although at a moderate rate, and that trade will remain above average for the time of year.

In general, retail sales were up after a flat month in September. Annual sales rose 16 per cent, less than the 24 per cent predicted by the CBI for October. Forecasters had suggested that sales for the time of year would only be down 2 per cent, but retailers reported them down by 14 per cent on the same time last year.

For wholesalers, sales volumes increased strongly in October, sales for the time of year were up 28 per cent on 1994 and orders placed with suppliers grew more strongly than expected (up 39 per cent). Stock levels are considered more than adequate to keep up with demand.

COMING EVENTS

TUESDAY, NOVEMBER 21

East Metropolitan Branch, RPSGB
Wanstead Library, Spratt Hall Road, Wanstead, London E11, 7.30 for 8pm. 'Gastro-intestinal problems – diagnosis and treatment' by Professor Duncan Colin-Jones.

Slough & District Branch, RPSGB
Postgraduate Medical Centre, Wexham Park Hospital, Slough, buffet from 7.15pm. Continuing education series, 'Skin cancer' by Dr A Jordan.

Ayrshire Branch, RPSGB
Piersland House Hotel, Troon, 8pm. 'Medical aspects of Air/Sea Rescue' by Dr J Begg, sponsored by Glaxo.

WEDNESDAY, NOVEMBER 22

Scottish Borders Branch, RPSGB
Education Centre, Borders General Hospital, 8pm. 'Young people and illegal/legal drugs' by Catherine Young, Borders Health Board.

THURSDAY, NOVEMBER 23

Bath & District Branch, RPSGB
Gainsborough Room, Pratts Hotel, Bath, 8pm. 'Oral cancer and mouth disorders' by M J Lutterloch and J Schnetler, consultants in oral and maxillo-facial surgery.

Fife Branch, RPSGB
Queens Hotel, Leonard Street, Perth, 8pm. Joint meeting with Dundee and Eastern Scottish Branch. 'The primary care pharmacist – a new entity?' by Bill Scott, chief pharmacist.

Dudley Branch, RPSGB
Medical Services Centre, Corbett Hospital, Stourbridge, 7.30 for 8pm. The Dennis Burkitt Memorial Lecture, entitled 'Prospects for reducing the burden of colorectal cancer', sponsored by Reckitt & Colman.

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TRADE LESS 30% - 2 Dextrostix (exp 2/96), 2 Havrix singles (exp 4/96), 162 Fucidin 250mg (exp 4/96), 1 Napratec (exp 12/95), 50 Pulmicort Respules 0.5mg/ml (exp 7/96). Tel: 0171-385 0355.

TRADE LESS 25% - Cardura 1mg 28x28, Minodiab `2.5' 8x60, Minodiab `5' 5x60, trade less 30% Ismo `20' 6x60. Tel: 01846 678128.

TRADE LESS 50% - Hydergine 1.5mg 30p, Calciparine 12560iu 80p, Hollister 4119x40p. Tel: 01960 322427.

TRADE LESS 50%+POSTAGE - 50 Genticin 80mg/2ml amps, 25 Fortum 2gm amps, 120 sodium chloride inj 5ml, 60 water for injections 5ml. Tel: 01292 314275.

TRADE LESS 30%+VAT - 2x300ml Zantac syrup, 60 Dyspamet, 56 Sectral 100mg, 33 Sectral 200mg, 80 Prover 400mg, 56 Orudis 100mg, 2x10ml Human Ultratard, 300ml Dyspamet liquid 4 Pregnyl 5000iu. Tel: 01443 772183.

TRADE LESS 30%+VAT - 50x28 Penbritin 250mg. Tel: 01242 226814.

TRADE LESS 25%+VAT+POSTAGE - 2x100gm Betnovate N, Hollister 3314, Locoid scalp application, Rythmodan, Sinequan 50mg, Robaxin 750, Atrovent 2.5mg. Tel: 0171-387 9585.

TRADE LESS 30%+VAT+POSTAGE - 122 Symmetrel 100mg (1/2000), 64 Megace 160mg (exp 10/97), 232 Parlodel 5mg, 82 Orimetin 250mg (exp 7/98), 54 Celance 025 (exp 1/97), 42 Trental 400 (exp 11/99), 44 Rimactane 300 (exp 3/98). Tel: 01702 203244.

TRADE LESS 25%+VAT - Sandimmun caps 100mg 1x30, Sandimmun caps 50mg 2x30. Tel: 01628 475917.

TRADE LESS 30%+VAT+POSTAGE - 2 Suprecur Nasal Spray, 345 Drogenil Tabs. Tel: 0181-767 6005.

TRADE LESS 50%+VAT - 3x10 Surgicare S300, 1x30 Hollister 2713, 2x30 Coloplast 5930, 1x30 Coloplast 5745, trade less 30%+VAT - 160 Rifater (exp 4/98), 247 Bradilan (exp 1/96), 85 Orap 2ml (11/97), 46 Negram (exp 3/96), 206 Tambocor 100m 98/99, 60 Loron 2x6x1ml Eprex 4000iu/ml, 4 Prefilled Eprex 4000iu/ml, 20 Retrovir 250ml (exp 3/97). Tel: 01705 581475.

TRADE LESS 25%+VAT - 30 Tagamet 300mg, 56 Capozide LS, 90 Manerix, 84 Rifadin 150mg, 30 Indomod 75mg, 80 Dipentum, 114 Trental 400mg, 414 Salazopyrin. Tel: 0181-785 3016.

TRADE LESS 30% - 300 Sinemet LS,

EXCESS STOCK CAUTION

Pharmacists are responsible for the quality, safety and efficacy of medicines they supply. In purchasing from sources other than manufacturers or licensed wholesalers, they must satisfy themselves about product history, conditions of storage and so on.

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TRADE LESS 30%+VAT+POSTAGE - 47 Lederfen 450mg, 28 Pepcid 20mg, 50 Naprosyn EC 500mg, 2 Pulmadil Inhaler, 20 Combivent UDV's 2.5ml, 1 Traxam Foam, 9 Instillagel 6ml, 55 Lopresor 50mg. Tel: 01963 250259

CONVATEC S312, S320, S353 - Biotrol Elite 328-35, Coloplast MC 5740. Tel: 01963 250259

TRADE LESS 50%+VAT+POSTAGE - Risperdal 4mgx22, Nitro-Dur 0.4mg Patchesx28, Betaloc 100mgx80 (All exp 12/95). Tel: 01269 850302.

TRADE LESS 30%+POSTAGE - Suprecur Nasal Spray 2 (Exp 1/96), Hollister Urostomy Pouch 1463 60 units, Propylthiouracil 50mg 93 (Exp 1/96), Accupro 20mg 28 (Exp 2/96), Axid Pulvules 300mg 28 (Exp 1/96), Mobiflex 20mg 28 (Exp 12/95). Tel 0181-670 0973.

TRADE LESS 20% - Eprex Pre-filled Syringes (exp 5/96), 2 Boxes of 6 3000 Iu/0.3ml Tel: 01361 883753.

TRADE LESS 40%+VAT+POSTAGE - Titralac x 354, Aldomet 250mg 85, Alucaps 118, Aldactone 25mgx17, Alupent tabs 94, Anquil 50, Allegron 25mgx42, Beta-Adalat 42, Epogam 175, Denoltab 52 (all long dated). Tel/Fax: 01332 342305.

TRADE LESS 20%+VAT - Xanax 500mg 2x60 (exp 9/96), Coracten 10mg 2x60 (exp 4/96), Coracten 20mg 1x60 (exp 10/96), Maxijul Super Soluble 3x650g (exp 1/98), Dermovate Scalp Application (exp 1/96), Nifensar XL 28 (exp 12/95), Migravess Forte 30 (exp 2/96), Tildiem Ret 120mg 3x56 (exp 10/96). Tel: 01827 262488.

TRADE LESS 30% - 2x500g Aminogran Food Supplement (exp 3/96). Tel: 01825 762959.

TRADE LESS 40%+POSTAGE - Scientific Hospital Supplies EO28 extra 40x100g orange flavoured (exp 5/96). Tel: 01670 512697.

TRADE LESS 20%+VAT - Scopoderm TTS patches, Blocadren 10mg, Betahistine 8mg, Cyprostat 100mg, Haldon 8mg, Bricanyl tabs, Finasteride 5mg, Droleptan tabs. Tel: 0181-349 2909.

TRADE LESS 25% - Risperdal 4mg, Cymevene 250mg Tel: 0171-620 0429.

TRADE LESS 30%+VAT+POSTAGE - 10x14 Flixotide diskhaler refills 500mcg (exp 12/95), 100 Olbetam 250mg (exp 3/97), 5x2ml Modecate, 4x30 Frisium caps, 5x2ml Modecate inj 50mg, 5x1ml Haldol 100mg inj Tel 0171-729 6151.

TRADE LESS 30%+VAT - 100 Imuran 50mg (exp 10/99), Hypoguard GA x5 (exp 10/96), 56 Innovace 10mg (exp 10/96), 56 Istin 10mg (exp 2/2000), 28 Adalat LA 60 (exp 5/96), 28 Motens 4mg (exp 2/96), plus many others. Tel: 01926 612858.

TRADE LESS 30% - Retrovir caps 250mgx60 (exp 4/98). Tel: 0121-327 4687.

TRADE LESS 25% - Tri-minulet, Ditropan 5mg, plus others. Tel: 0181-520 5820.

TRADE LESS 50% - Steri-Neb 2.5mg, Salamol, Steri-Neb 50mg tabs, Fungilin 100mg, Epogram Paed 80mg caps, Orap 4mg tabs. Tel: 0181-349 2909.

FOR SALE

TRADE LESS 30% - Inverness ear piercing kit with studs and cassettes. Tel: 0171-620 0429.

PMR SYSTEM - 1 year old, NPA approved, owings, MDS, Mar and Nomad, stock reports, interactions, full colour, hardware Windows, works, manuals, disks, £600. Tel: 01203 257930.

WANTED

TABLET COUNTER - Any quantity. Tel 0181-808 1974.

SCOPODERM PATCHES - Any quantity Tel: 0114-274 8116.

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18 Mulberry Gardens, Sherborne, Dorset.
Tel: 01935 816073 Fax: 01935 814181

With the festive season rapidly approaching us, we at **Chemist & Druggist Classified Section,** are offering you the opportunity to take a Christmas Message Box on the Classified Pages of the 16 December issue of the magazine.

To put your "Season's Greetings" in front of 41,000 readers, or for further details, please contact **01732 377310, or fax on 01732 368210.**

ABOUT people

Hadley to stand in West Worcs

The Lib Dem's Mike Hadley

Mike Hadley, best known to pharmacists through his computer company Hadley Hutt, is moving into politics in a major way.

Mike, who stood for the Liberal Democrats last year at the Dudley by-election, has now been selected for the constituency of West Worcestershire.

In Lib Dem terms, this is a 'starred seat', meaning it can be won. "The party targets its resources carefully," says Mike. "It cannot fight 650 seats flat out, so puts its effort into seats it can win."

The area is currently Tory, but, with a full-time political agent to support him, he hopes to change that at the next general election.

In the May district council elections, the two councils within the constituency returned 23 Liberal Democrat councillors out of a possible 45. Five council wards went to the Conservatives and two to Labour.

This year's Leslie Matthews Medal was awarded to retired pharmacist Dr Nita Burnby for her research into the history of pharmacy. The award was presented by Anthony Morson, president of the British Society for the History of Pharmacy, at the RPSGB headquarters last week

Following in the steps of Dick Whittington

Last week's Lord Mayor's Show was a special occasion for retired pharmacist Aileen Chalstrey. It marked the start of her year as lady mayoress after her husband, John, became the 668th Lord Mayor of London.

Mrs Chalstrey, whose husband is a surgeon at St Bart's Hospital in London, was driven by carriage in a procession watched by a 250,000-strong crowd. The theme for this year's parade was, appropriately enough, 'Good health to the City and the nation'.

Mrs Chalstrey says she is very excited about her new role. "There is a certain amount of trepidation in what lies ahead, but I have had lots of support."

One of her first tasks will be opening the Red Cross Christmas Market in the Guildhall and switching on Bow Lane's Christmas lights. Mrs Chalstrey worked for Boots before joining her husband's Harley Street practice.

Lady mayoress Aileen Chalstrey

APPOINTMENTS

Bridie Collins has been appointed general manager of Castle Pharmaceuticals, a subsidiary of the Intercare Group. The appointment follows the retirement of Pat Burns, who set up the company in 1981 and who held the post of managing director. Mr Burns will maintain his current position on the board of Impharm Nationwide as a non-executive director.

Sanofi Winthrop has recruited **Sara Woodiwiss** as commercial manager responsible for customer services and national accounts.

G Kirk Raab has been made chairman of the board of Oxford Glycosystems. He was previously president and chief executive of Genentech.

National Power chairman **John Baker** has joined the board of Medeva as a non-executive director.

Dr David Yost is now with Celsis International as senior vice president for global research and development.

Medevale Pharmaservices announces two new appointments: commercial manager **Alan Lahaise** and account manager **Tom Tavener**.

Shopfitter Beanstalk has promoted **John Copping** from senior contracts manager to service director.

10,000,000

With this many smokers in Britain wanting to quit, we'll make sure your sales light up.

And how will we hook them? Firstly, by launching a massive £4.5 million ad campaign to teach smokers how Nicotinell patches work. Which means doubts about the relative harm from nicotine should go up in smoke. Secondly, by introducing a brand new, great tasting Nicotinell gum. And thirdly, by helping you to help your customers, with POS material and product information guides. We're already brand leaders with 59% of the patch market, and this new drive will leave the competition fuming. So make sure you're well stocked up with packs of Nicotinell Patches and Nicotinell Gum. You'll be amazed how many you get through.

PRESENTATION Transdermal Therapeutic System containing nicotine, available in three sizes (30, 20 and 10cm²) releasing 21mg, 14mg and 7mg of nicotine respectively over 24 hours. Nicotine chewing gum containing 2mg nicotine, in original and mint flavour. INDICATION Treatment of nicotine dependence, as an aid to smoking cessation. DOSAGE Stop smoking completely when starting treatment. PATCH For those smoking more than 20 cigarettes a day, treatment should be started with NICOTINELL TTS 30 once daily. Those smoking less should start with NICOTINELL TTS 20 once daily. Sizes 30, 20 and 10cm² permit gradual withdrawal of nicotine replacement, using treatment periods of 3-4 weeks with each size. Doses above 30cm² have not been evaluated. The treatment is designed to be used continuously for three months, but not beyond. However, if still smoking at the end of the three month period, further treatment may be recommended following a re-evaluation of the patient's motivation. GUM One piece of gum to be chewed when the user feels the urge to smoke. Normally, 8-12 pieces per day, up to a maximum of 15 pieces per day. After 3 months, the user should gradually cut down the number of pieces chewed. CONTRAINDICATIONS Non smokers, occasional smokers, children under 18 years. As with smoking, NICOTINELL is contraindicated during acute myocardial infarction, unstable or worsening angina pectoris, severe cardiac arrhythmias, recent cerebrovascular accident, pregnancy and breast feeding, skin diseases preventing patch application and known hypersensitivity to nicotine. PRECAUTIONS Hypertension, stable angina pectoris, cerebrovascular disease, occlusive peripheral arterial disease, heart failure, hyperthyroidism, diabetes mellitus, renal or hepatic impairment, peptic ulcer. Persistent skin reaction to the patch. KEEP OUT OF THE REACH OF CHILDREN AT ALL TIMES. SIDE EFFECTS Smoking cessation causes many withdrawal symptoms. Events which may be related to smoking cessation include headache, sleep disturbances, gastro-intestinal disturbances, and myalgia. NICOTINE PATCHES Most common adverse effects are reactions at the application site (usually erythema or pruritus). NICOTINE GUM May cause throat irritation, hiccupping, minor indigestion or heartburn. LEGAL CATEGORY P. PACKS NICOTINELL TTS 10 (PL0001/0173) in packs of seven patches, trade price £8.21, retail price £14.47. NICOTINELL TTS 20 (PL0001/0174) in packs of seven patches, trade price £8.64, retail price £15.23. NICOTINELL TTS 30 (PL0001/0175) in packs of seven patches, trade price £9.07, retail price £15.99. NICOTINELL Original Chewing Gum 2mg (PL0001/0195) and NICOTINELL Mint Chewing Gum 2mg (PL0001/0197) in packs of 24, trade price £2.57, retail price £4.50, and packs of 96, trade price £7.70, retail price £13.50. ™ denotes registered trademark. PL HOLDER Ciba-Geigy plc, Macclesfield SK10 2NX. Further information is available from Zyma Healthcare, Holmwood RH5 4NU. DATE OF PREPARATION October 1995. 1294/655

ZYMA HEALTHCARE IS PART OF THE CIBA GROUP

Sources: TGI, Omnibus Survey Mar 1994, Nielsen J/A 1995. 'Nicotinell' is a designated trademark. Nic 12/95

THE BIGGEST NEWS FOR EARS IN YEARS

- Otex is now the undisputed brand leader amongst proprietary ear wax preparations.
- The total value of the ear wax market has grown a staggering 37% since Otex was launched.
- In-pack survey results show 9 out of 10 users find Otex effective.
- Almost 90% of Otex purchasers surveyed said they would buy Otex again.

And here's why...Otex has a unique, dual-action formula that not only softens hardened ear wax but then goes on to help it fragment and disperse. Otex is clinically proven to reduce the need for syringing.

With a massive, new national TV and press campaign scheduled for this year, it can only mean one thing ... even bigger news for your pharmacy sales.

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CLINICALLY PROVEN TO DISPERSE EAR WAX AND REDUCE THE NEED FOR SYRINGING

OTEX Registered Trademark and Product Licence held by Diomed Developments Ltd , Hitchin, UK. Distributed by DDD Ltd , 94 Rickmansworth Road, Watford, Herts, WD1 7JJ. **Active Ingredient:** 5.0% w/w Urea hydrogen peroxide **Directions**: Tilt head, and gently squeeze 5 drops into ear. Leave for a few minutes and then wipe surplus with tissue. Repeat once or twice daily for approximately 3-4 days or until symptoms clear. **Indications:** For the removal of hardened ear wax. **Precautions**: Do not use if sensitive to ingredients, if ear drum is damaged. If there is any other ear disorder (such as inflammation), or if any other preparation is being used in the ear. If in doubt, or if there is a history of ear problems, seek medical advice before use. Keep away from eyes. If irritation or pain occurs during use, or if symptoms persist, stop treatment and consult your doctor. Keep all medicines out of the reach of children. FOR EXTERNAL USE ONLY **Legal category:** P **Packs**: Bottles of 8 ml (PL 0173/0151), price £3.25 4/95